

About GIH

Grantmakers In Health (GIH) is a nonprofit, educational organization dedicated to helping foundations and corporate giving programs improve the nation's health. Its mission is to foster communication and collaboration among grantmakers and others, and to help strengthen the grantmaking community's knowledge, skills, and effectiveness. Now celebrating its 20th year, GIH is known today as the professional home for health grantmakers, and a resource for grantmakers and others seeking expertise and information on the field of health philanthropy.

GIH generates and disseminates information about health issues and grantmaking strategies that work in health by offering issue-focused forums, workshops, and large annual meetings; publications; continuing education and training; technical assistance; consultations on programmatic and operational issues; and by conducting studies of health philanthropy. Additionally, the organization brokers professional relationships and connects health grantmakers with each other as well as with others whose work has important implications for health. It also develops targeted programs and activities, and provides customized services on request to individual funders. Core programs include:

- C **Resource Center on Health Philanthropy.** The Resource Center monitors the activities of health grantmakers and synthesizes lessons learned from their work. At its heart are staff with backgrounds in philanthropy and health whose expertise can help grantmakers get the information they need and an electronic database that assists them in this effort.
- C **The Support Center for Health Foundations.** Established in 1997 to respond to the needs of the growing number of foundations formed from conversions of nonprofit hospitals and health plans, the Support Center now provides hands-on training, strategic guidance, and customized programs on foundation operations to organizations at any stage of development.
- C **Building Bridges with Policymakers.** GIH helps grantmakers understand the importance of policy to their work and the roles they can play in informing and shaping public policy. It also works to enhance policymakers' understanding of health philanthropy and identifies opportunities for collaboration between philanthropy and government.

GIH is a 501 (c)(3) organization, receiving core and program support from nearly 200 foundations and corporate giving programs each year.

Foreword

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This report features several major speeches delivered at Grantmakers In Health's 2002 Annual Meeting on Health Philanthropy, *On Solid Foundations: Strengthening the Future of Health and Philanthropy*. As GIH celebrated its 20 years of service to the field, the meeting explored the changing health landscape and how the aging of the nation's population, its growing racial and ethnic diversity, the rapid pace of new discoveries in science and medicine, and the continuing transformation of the nation's health care delivery system will affect the health of individuals and communities. Breakout sessions, mini-plenaries, site visits, and a poster session provided other opportunities for health grantmakers to reflect on their collective accomplishments and figure out how best to tackle the challenges that lie ahead.

Lauren LeRoy analyzed the changes in the nation's health and its health system since the early 1980s and mapped out the challenges facing health grantmakers as they contemplate the future.

Bruce Vladeck reflected on the experience of being a New Yorker in the aftermath of the September 11th attacks, and shared his wisdom about the needs of the nonprofit sector.

Ian Morrison made us both laugh and think as he looked into his crystal ball. His comments on the new principles of health care purchasing suggested roles and actions for health grantmakers in shaping an ethical and equitable health system.

Steve Schroeder, soon to step down as president and CEO of The Robert Wood Johnson Foundation, shared with us the seven lessons he has learned over his years in philanthropy.

Martha Katz, stepping in at the last minute for Centers for Disease Control and Prevention director Jeffrey Koplan, sketched out the public health challenges facing the nation, and opportunities for philanthropy to support the CDC in its work and bolster the public health infrastructure in communities.

Tony Proscio took us back to English composition class, and showed us the value of a plainly written sentence. His comments on trust and power illuminated the need for grantmakers to be honest in communication and relationships with their grantees.

Terri Langston and Tom David inspired us to examine the true meaning of our work and to make the most of the tremendous privileges that our position in philanthropy provides.

Our thanks to them and to all the other speakers at the meeting who shared new information, insights, and strategies to help grantmakers improve the nation's health. Our thanks as well to Anita Seline for her efforts to transform the speeches in this volume from the spoken to the written word.

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A Look Into the Future Through the Lens of the Past

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Not much more than a year ago we were all talking about a strong economy, peace at home, a large budget surplus, increased foundation assets and giving, the impact of the new venture philanthropists on the field, and the potential for the unprecedented intergenerational transfer of wealth to vastly increase foundation formation and charitable giving. Today, only this last development, which is slated for the future, remains on the table. What a difference a year makes. Today, “changed priorities ahead” seems to have become the mantra for federal and state policymakers, business leaders, and many health grantmakers.

When conditions can change so rapidly, how do we plan for the future or try to affect it? How do we anticipate what the critical issues facing society will be? Some of the issues that will challenge health philanthropy are already apparent today. For others, current conditions suggest what the future may hold. While in still other cases, we must accept that what the future holds remains unknown and possibly unsettling.

Two Decades of Trends

Planning for the future involves looking back as well as forward. Reflecting on our past can provide very useful insights into the future, or our possible futures. The 20th anniversary of Grantmakers In Health creates a natural opportunity to look back and take stock of the progress and problems that we face in improving the nation's health. Twenty years does not seem like such a long time, and it certainly is not in the course of history. Nonetheless, we have witnessed some dramatic changes in just these two decades in our nation and its health statistics.

Our Nation

There are 50 million more Americans today than there were 20 years ago. With more people, you would expect higher health expenditures, and we have seen substantial increases in spending. In addition, costs today are five times what they were 20 years ago (rising from \$247 billion to \$1,542 billion), reflecting both higher utilization of services and higher costs per unit of service. At the same time that costs have been rising, we have seen more and more people lacking insurance coverage. Even in times of economic boom, with lower rates of unemployment, the number of uninsured continued to rise. Today we find that eight out of ten people who do not have insurance are in working families.

Our Children

The percentage of children living in poverty has declined (from nearly 22 percent to 16 percent), but millions of children are still poor. The number of children killed by firearms peaked in 1994 at 5,700 and has steadily declined to about 3,400 today. Even these lower numbers, however, translate into a

tremendous loss of life and potential. And even though we have seen a reduction in smoking by children, if current trends in tobacco use continue, more than 5 million children who are alive today will die prematurely from smoking-related illnesses.

Our Aging Population

We have seen striking changes in our elderly population over the last 20 years. The number of Medicare beneficiaries has increased from about 28 million to 39 million, with Medicare expenditures rising from \$45 billion to \$237 billion. These changes, however, will be dwarfed when the baby boomers move into retirement. We keep thinking that we have time to prepare for that future, but that day is just around the corner. By 2030, 69 million Americans will be over the age of 65, with 20 million of them being 85 years or older, putting pressure on nursing homes, community-based long-term care services, and families. We face a serious crisis in caregiving if we do not do something about this quickly. In 1970 there were 21 potential caregivers for each elderly person. By 1990 that number had already dropped to 11:1, and by 2030 it will drop to 6:1.

Our Health Workforce

The number of physicians has grown from 502,000 to nearly 757,000 since the early 1980s, but numbers alone do not tell the whole story. We have a continuing and growing disconnect between the composition, distribution, and training of the physician workforce and the patients they serve, particularly racial and ethnic minorities and the elderly. Just at the time when nurses are most needed, we are going to find it increasingly difficult to attract and retain them if we do not take aggressive action. If current trends continue we could face an estimated shortfall of 80,000 nurses by 2020 and their average age will be 50 years.

Public Health Challenges

It is remarkable to consider that just over 20 years ago there had been no reported cases of AIDS in the United States. Twenty years later, we have over 320,000 AIDS cases reported, with 800,000 to 900,000 people in the United States and over 36 million people around the globe living with HIV infection.

On a happier note, we can look at the data on seatbelt use and see the tremendous progress that has been made, which translates into lower mortality rates for automobile accidents. The proportion of American adults who buckle up regularly has increased from 19 percent in the early 1980s to 81 percent today. We have also made some progress on reducing the proportion of people over age 25 who smoke from 30 percent to 23 percent during the past 20 years, but it is clear that there is a lot more to be done.

One of the biggest surprises for me is that, during a period when attention to physical activity, low-fat diets, and the marketing of healthy living seems to have been at a fever pitch, a silent epidemic of overweight and obesity has emerged in this country. In the year 2000, all states but Colorado had obesity rates of greater than 15 percent. Not a single state was classified as such in 1985. At the beginning of this new century, more than 60 percent of adults in this country are now overweight or obese, and at least 13 percent of children are overweight.

Just 10 years ago, the threat of using infectious disease pathogens as weapons of terrorism and war was brought home to us by images from the Gulf War. But it still seemed remote to us and did not materialize on our own shores. Today we no longer harbor illusions that this could never happen here.

The Information Revolution

In the same year that brought us the first genetically engineered vegetable approved for sale and the first permanent artificial heart, *Time* magazine parted with tradition in 1982 in choosing its Man of the Year. This distinction, annually given to “the greatest influence for good or evil,” was bestowed not on a man but on a machine. It was the computer. *Time* declared that with the information revolution, America would never be the same. In 1980, 724,000 personal computers were sold. The number last year was closer to 4 million. Twenty years ago there was no Internet. Today there are over 143 million Internet users in the United States. Such growth alone provides insight into why this technology has generated such excitement and concern about its use in the health sector.

Changes in Philanthropy

Philanthropy also has experienced considerable change during this same period, putting it in a position to bring more resources to bear on the issues we face both in this country and around the world. The number of foundations has grown from nearly 24,000 in the early 1980s to 65,000 today. Over that period, foundation assets have climbed from \$59 billion to \$449 billion, with giving increasing from \$4.5 billion to over \$23 billion. We all know what the strong economy and the changing health care system — until this year — had meant for health philanthropy in the last 20 years. Funding for health ranked second after education and averaged about 16 percent to 17 percent of giving over most of the 1990s. Philanthropic giving in health reached \$3 billion last year, a ten-fold increase over giving 20 years ago.

A Century's Worth of Progress

If we look back even further over the last century, we see dramatic improvements in health and life expectancy. To celebrate that success, the Centers for Disease Control and Prevention (CDC) has highlighted the 10 great public health achievements in the United States since 1900. They comprise an impressive list.

- C The development of vaccines and childhood immunization programs have eradicated or controlled a number of diseases such as smallpox, polio, and measles.
- C Practices to decrease contamination, increase nutritional content, and improve labeling for healthier choices have created a safer food supply.
- C Family planning has allowed people to control family size and space births. It has provided entrée to counseling and prenatal care, and it has helped prevent transmission of sexually transmitted diseases.

- C Public education about the risks of smoking, promotion of smoking cessation, and restrictions on advertising and smoking in public places are reducing the prevalence of smoking among adults.
- C Improved sanitation and hygiene, animal and pest control, the introduction of antibiotics, and advances in the detection and the tracking of diseases have all contributed to very impressive reductions in death rates from infectious disease. The problem, of course, is never completely solved. Today we face new challenges with HIV/AIDS, the resurgence of tuberculosis, and new drug-resistant strains of bacteria.
- C Improvements in standards of living, medical care, nutrition, education, prenatal care, and immunizations have produced dramatic declines in maternal and infant death. But before we pat ourselves on the back, let us not forget that we still have significant disparities by race and ethnicity. Black infants are twice as likely to die as white infants, and the gap in maternal mortality between black and white women has actually increased since 1900.
- C We have witnessed large reductions in motor vehicle-related deaths as a result of laws regarding seatbelt use, child safety seats, helmet use, speed limits, and drinking and driving, in addition to advances in automobile engineering.
- C Particularly in the last 20 years, measures to protect workers, and to retool the workplace to reduce risk (especially in the fields of mining, manufacturing, and construction) have resulted in a reduction of roughly 40 percent in the rate of fatal work-related injuries.
- C Prevention efforts (such as changes in diet, exercise, and smoking), early detection and treatment (particularly for hypertension and elevated cholesterol), and advances in medical care for heart attack and stroke have all contributed to declines in death rates for these major killers.
- C Finally, the last on the CDC list is fluoridation, which has made a major contribution to reducing tooth decay in this country. In 1900, most people could expect to lose all their teeth by age 45. Today, with widespread fluoridation and other prevention strategies, most people can expect to keep their teeth throughout their life.

We could add to this list advances in medical care and medical technology that have allowed people to regain good health and function and to remain productive members of our society. The story, however, is a mixed one and I have an enduring memory that I would like to use to help make this point.

I can remember as a child leafing through old family photographs and being captivated by a portrait of my mother's cousin Hazel. To me she was youthful, innocent, beautiful, the quintessential image of her era. I feel that way today all these years later when I look at that picture. Hazel died of pneumonia at age 23. The antibiotics that could have saved her life had yet to be developed. How tragic, I thought, as a child, looking at this picture. How lucky I felt to be protected from such an untimely and unfair death, to be living in a time of great medical advances.

But today I see how quickly we could find ourselves in Hazel's shoes, as our overuse and misuse of antibiotics render them ineffective in combating diseases that we once thought we had conquered. I

have also come to recognize that many around the world and here at home could face Hazel's fate today simply because of an accident of birth that keeps them outside of the mainstream of common medical care.

Progress Produces More Challenges

Clearly, we have seen dramatic progress in both medicine and health over the past century. But while we celebrate these impressive accomplishments we should remind ourselves that for each victory have emerged often more complex challenges, sometimes ironically created by the scientific and social advances themselves, and sometimes allowed to gain public attention as more immediate issues have been solved.

At times we face a completely new threat, such as the AIDS epidemic, or dazzling new frontiers that can dramatically change our lives, such as the breakthroughs in information technology and the human genome. But many of the issues that we face today are variations on themes that have been with us as far back as we care to look:

- C tackling infectious disease;
- C structuring services and policies to address the major causes of illness, more of which are now chronic in nature;
- C reducing inequality and disparities that bring the fruits of our progress to some at the expense of others;
- C putting the protection of disease, injury, and disability above personal and corporate financial gain;
- C balancing public, private, and individual responsibility for maintaining a healthy and productive society;
- C creating a society that cares for all its children and elderly;
- C struggling over the priorities that should be placed on encouraging healthy behaviors versus developing treatments for the consequences of unhealthy lifestyles;
- C appropriately allocating resources that are limited (no matter how large they may seem) among medical care and public health to get the greatest return on our investments;
- C finding the proper balance between addressing immediate needs and working for structural change in the conditions that gave rise to those needs;
- C understanding the interrelationships between the social, behavioral, and scientific factors that ultimately determine health and quality of life;

- C being technology's master rather than its captive;
- C thoroughly applying what we already know for maximum impact;
- C understanding that the determinants of our nation's health and the strategies for improving health are not confined to our borders; and
- C grappling with the ethical and moral issues that both accompany scientific and technological advances and arise from our decisionmaking about who in our society will be able to gain access to needed services.

Implications for Health Philanthropy

The list of leading health indicators issued by the Surgeon General as part of Healthy People 2010 reinforces this picture of continuity and change. It encompasses longstanding issues, like access to health care, with both issues that are not new but have received less public attention, like mental health, and issues that only recently have emerged as national concerns, like obesity. Issues such as these and the challenge of chipping away at them are why I suspect most of you were drawn to philanthropy.

This period in which you are working has been one of greater self-evaluation and greater public scrutiny for foundations. Both should motivate you to think about the elements of effective grantmaking that must accompany your critical thinking about the issues you are addressing.

Among those elements are:

- C establishing clear, predictable, and respectful relationships (the rules of fair play) with grantees who ultimately carry out the foundation's work;
- C weighing the benefits and implications of supporting critical core functions of an organization as opposed to giving specific project grants;
- C thinking up front about how to sustain the activities in which the foundation invests;
- C being effective and open in communicating about the foundation's mission, work, expectations for itself and its grantees, its successes and failures, and the lessons from which others can benefit;
- C continually questioning what you are doing, what you have done (maintaining a healthy dose of skepticism), and not being afraid to change; and
- C having a theory of change and relevant methods for assessing whether the work that the foundation supports or undertakes has been effective.

This last element of assessing effectiveness has become a growing preoccupation in philanthropy, and it is one that we at Grantmakers In Health have also been exploring. In his last annual report essay

before stepping down as president of the James Irvine Foundation, Dennis Collins voices a strong cautionary note about the “rush to outcomes-based philanthropy.” He echoed the sentiments of Ira Cutler, formerly of The Annie E. Casey Foundation, who noted that “the hyper-emphasis on measurable outcomes is creating a system in which we cannot admit that evidence is scant and shaky, and where we have to continue pumping up expectations about not only our successes but our ability to measure success” (Sievers 2001).

Doing a better job of evaluating what you fund is responsible and strategic, but let us be honest about what we expect from our efforts to evaluate and measure. Otherwise we run the risk of creating unrealistic expectations among grantees, the public, and within our own organizations; and the incentive to be imaginative and take risks diminishes. In a recent lecture, Bruce Sievers of the Walter and Elise Haas Fund noted that, “Venture capitalists assume that for every 10 investments there will be four abject failures, four walking wounded, and maybe, if you are really lucky, one or two real hits” (Sievers 2001). As we try to do a better job of assessing the work of philanthropy, perhaps the first step should be to set realistic standards for what the return on investment in addressing what are often complex, messy, high-risk problems, should be.

Foundations have shown the capacity to change over this last century, to adapt to new challenges in the environment in which they operate. In the early years of the 20th century, foundations such as Carnegie and Rockefeller sought to apply the tools of social science and the organization and planning methods of business to society's social problems. They became leaders in social planning, urban planning, public health, and education reform.

It was only during the Depression and World War II that the federal government began to make a major investment in social planning and, with that, dwarfed the contributions of organized philanthropy. As Terrance Keenan pointed out in a monograph written for the 20th anniversary of The Robert Wood Johnson Foundation, the “gargantuan size of the national health bill makes foundation spending appear almost marginal” (Keenan 1992).

But before we get too carried away with these relative comparisons of foundation assets and government spending, let us remember that even in this period of national crisis, economic downturn, and stock market decline, organized philanthropy still has billions of dollars to direct towards health improvement.

One thing we can be sure of is the inevitability of change and the uncertainty that it implies for the future. As Edward Skloot of the Surdna Foundation pointed out in an editorial in the *Chronicle of Philanthropy* last November, national priorities can change radically, practically overnight. Anticipating the administration's budget response to the recession, war, and terrorism he noted that “the red ink of government will cover everything that we grantmakers do for the foreseeable future.”

At the same time, foundations are in a position to help shape that future by the decisions they make and the actions that they take; the decisions you make and the actions that you take. How flexible and prescient foundations will be in anticipating the issues and needs, how willing they are to be agents of change, and how daring they will be in practicing according to their core values (particularly in difficult times), will determine whether the health foundations in this country have seized what Terrance Keenan described as the “unparalleled opportunity to become full and visible partners” in the nation's social contract.

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A Grantmaker's Agenda for the Future

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Grantmakers In Health asked if I would say a few words about New York City and health care and philanthropy in light of events on September 11th and thereafter. I take very much to heart the challenges of the particular times in which we find ourselves, and how the economic circumstances, if nothing else, compel us to take stock and think a little bit about habits we have formed in recent years.

To start with the events of September 11th, my family and I were particularly fortunate in the limited personal damage we suffered from the events of that day. But everybody in New York has a story, and I want to tell you mine.

In June 2001, I attended a banquet in the Winter Garden. Those of you who were familiar with lower Manhattan know that the Winter Garden was part of one of the world's more elaborate and upscale malls, created at the ground level of the World Financial Center. The eastern edge was a bridge over to the World Trade Center with a monumental staircase coming down from there into the main lobby, underneath a glass ceiling reminding one of the Crystal Palace, into a room filled with enormous foliage. It was an incredibly dramatic indoor space.

My own connection to the Winter Garden came from the fact that all three of my kids went to elementary school in that neighborhood, about three blocks from the World Trade Center. And every year, at the start of the Christmas shopping season, in an aura of the most crass kind of commercialism and abuse of public education, they would kick off the Christmas shopping season on those steps. The orchestra and chorus from P.S. 234 would perform the appropriate seasonal songs, which in New York meant that they sang some Christmas carols and some Hanukkah songs and some Kwanzaa songs.

In those days, it was always an adventure getting down to that neighborhood and getting back because it was an area relatively recently settled, surrounded by all sorts of construction.

When I was down there in June, what struck me was how enormously vibrant and exciting a community it had become. When my kids started going to school in that area, there was no street life at night. There were three or four apartment buildings in Battery Park City. There was no weekend activity. Now there were new movie theaters, new parks, new activities of one sort or another. And on that particular evening, there were two or three restaurants with open air bars absolutely jammed with young people spending money and having a good time in this brand new neighborhood, which I had seen grow up literally from the landfill.

The Winter Garden will be restored relatively soon. A lot of the glass was broken and it was filled with debris, but otherwise it was not structurally damaged. The fact that there is a continuing impact on our city, however, is not obvious unless you are here all the time. There is a measurable financial

impact. There is a measurable and serious continuing impact on public transportation in the city, cushioned slightly by the recession but which will get substantially more serious over time. There are major issues of community development. We have all learned a lot about wartime psychology and the effect of stress and the management of posttraumatic stress disorder in large populations.

But I want to try to convey to our visitors, not in a complaining way but just by way of explanation, the fundamental fact that there is a hole in the middle of our city and the middle of our lives. And that hole is going to be there for a very long time. And there is no way to escape it or not see it, and it has an impact on every aspect of daily life in ways that are not very visible. It is really unlike anything any of us have experienced, certainly in my lifetime.

The hole obviously extends beyond the immediate area of Ground Zero, and through the whole neighborhood. There has been a calamitous permanent change in the fabric of the city's life, as well as in the lives of lots of people, and it will take us many years before we fully comprehend it. That is the environment in which we are living and some of the challenges to which, specifically in this city, we are responding.

Some of the response, of course, has been quite remarkable. I think for everyone involved in the philanthropic community, in some ways the most important thing to say about the events of September 11th and the period immediately thereafter was how extraordinary was the outpouring of philanthropy from individual Americans and individual households. It will probably be quite some time before we get a full accounting, if ever. But it is probably fair to say that, in terms of individual contributions and individual donations, never before in history has so much money been raised from so many separate contributors so quickly and so dramatically.

It is a reminder that while the foundation world is not exactly typical in this regard, if you look at philanthropy as a whole in the United States, what is most striking is the extent to which individual philanthropy continues to be vitally important to the support of religious, educational, and health care institutions. And the place where behavior in the United States really differs most dramatically from that of many other parts of the world is the strength of those traditions of individual giving, typically from households of relatively modest income.

We speak all the time about the implications of organizing services for the middle class and the politics of the middle class and the mastery of some of that politics by former President Bill Clinton, and now by the new administration in Washington. It is important to remember that while the middle class may be, appropriately, the subject of some public policy discussions, they are also the primary source of philanthropy and philanthropic giving in the United States. We do not remember that clearly enough or think about it strategically enough except in extraordinary circumstances.

The other big lesson that we relearned is the cliché that everyone in the philanthropic world always remembers and knows is true: it is much easier to raise money than to spend it wisely or appropriately. It has been quite striking, in the aftermath of September 11th, how much difficulty some of the largest, best established, and best organized charitable organizations in the United States have encountered trying to spend the money wisely.

There have also been some wonderful stories in the press that I hope you have seen, about organizations such as the National Association of Homebuilders, for example, that had never before

tried to engage in organized giving, that devoted a lot of time and effort to raising money. Then, faced with the challenge that all of you face every day of trying to figure out how to spend it appropriately and wisely and fairly, they were totally baffled and astonished by how hard it seemed to be.

Doing Better in the Grant Business

These recent events and the circumstances in which we find ourselves raise at least six issues about the ways in which we customarily do business, the ways in which we have increasingly done business in recent years, and whether that is the appropriate and best way to do things.

The first question I will raise is, “what is so bad about core support, nonproject-specific support?” If organizations are performing an important social function that is inherently uneconomic, for which revenue will never cover appropriate expenses, why shouldn't we provide them with some basic support for their basic activities? And maybe more immediately, why should we divert or distract their attention from that which they are really good at? That may be the fundamental day-to-day activities of the organization, instead of writing of grants or the development of special projects, or the attempt to come up with some sort of novelty rather than continuing to focus on that which they do well and which may be most important.

A second question is “what is wrong with continuing support?” The foundation community is one of the few areas of organized activity I have encountered that, by and large, has adopted as a matter of policy the philosophy that if you do something that is extremely successful, you stop doing it and move to something else.

The fact of the matter is that we ought to know by now that many of the most important activities supported by philanthropy will survive only if they continue to be supported by philanthropy. When I first got into this business in the early 1980s at The Robert Wood Johnson Foundation, it was still possible to assume that if the foundation community demonstrated a better way of providing some human service or a better way of organizing health services, once that demonstration was clearly established, the public sector would step in to pay for it. Of course, I was at the foundation at exactly the time that that assumption ceased being true as a matter of public policy in the United States. And it continues to be less true all the time.

An unkind interpretation (which of course I would never personally engage in) is that when you provide continuing support to conventional grantees rather than looking for new projects and new activities for funds, there is a whole lot less for foundation staff to do and fewer interesting presentations to make to the board as well. And so the insistence on novelty and new ideas and not supporting continuing activities may be functional in the broader sense of organizational maintenance. But I am not sure, in the world that we now occupy, that it really fits with the way services evolve and develop and move forward.

There is a third issue, which is sort of a pet issue of mine. I have talked about this with no success, maybe because, in my 10 years at the United Hospital Fund, we enforced very strenuously the approach I am now criticizing. But if you are making grants to small nonprofits without considerable financial reserves or considerable public sector funding, then I think that the refusal to pay overhead on projects is fundamentally indefensible. The temptation to do it is amazing. But you are insisting

that your grantees either engage in some fundamentally dishonest behavior or go out and spend money to raise money to keep up with the support you are providing them. They eventually get into a financial trap where the more successful they are in raising soft money project grants, the larger their financial problems become and the more serious the long-range jeopardy to the organization. Again, I make that point, acknowledging that for a large part of my professional career, I was complicit in that policy.

Fourth, after talking to folks involved in program development and expressing my own frustration and impatience with some of what is happening, I am reminded that important changes that take place in human services and community development, and in the delivery of care, just intrinsically take a long time. Not only does it take a long time to accomplish them, but it may take a fair amount of time after they have been accomplished to fully understand and recognize what has, in fact, been accomplished. And organizationally, institutionally as well as personally, most of us do not have an attention span that matches the realities of starting new things and succeeding with new things in a very complicated, very unstable world.

At Mount Sinai, we are now in the sixth year of the development of our PACE program, which ought to become self-sustaining sometime in 2003. And it is a good program. We are providing excellent services to about 40 people in the community who otherwise would not get it. By next year we will serve a couple of hundred. We could have done some things faster, but if we had cut the development time in half it still would have taken us three-and-a-half years to get to the early startup stages we now occupy.

There is no noninstitutional source of funding that would have been available to us that would still be around at this point, which is financially the most perilous and touchiest time in the whole process. This is a program built on well-established models, and that is supported at the end of the day by a couple of institutions with very deep pockets. If we had been trying to do this on a totally independent basis we could not have done it.

Just two last points I want to make. One of the things we do not do enough of, but one of the most effective things that's been done in this city by the philanthropic community since September 11, and one of the things that has generated an enormously positive response, is what the Andrew Mellon Foundation did.

What that foundation did was really quite radical and quite novel. The Mellon Foundation was very much concerned about the impact of the events of September 11th and some of the subsequent economic effects on small arts organizations in New York City, particularly those in Lower Manhattan. They wanted to do something to respond to what they perceived as a potential crisis. It was not immediately obvious what it was that they should do with some finite amount of money that would be most effective. So they got this extraordinarily radical and creative idea, and they went out to the organizations and they asked them what they needed and what would be of most help to them, what they were most worried about, what their immediate problems were, and so forth.

Amazingly enough, most of the potential grantees told them just what it was they needed, and so the Mellon folks went back to their offices and went back to their boards and they organized a grant program to respond to what the potential recipients thought they needed.

I think that the more sophisticated we get, the more professional foundation staff get, the more knowledgeable we get about all these things, and the better our technologies get, the higher the risk is that we will have conversations among ourselves about the best way to provide assistance for people in grantee land.

My own guiding spiritual leader and source of most wisdom, Yogi Berra, is reputed to have said that you can observe a lot just by watching. You can learn a lot about the needs of potential grantees just by talking to them. From a grantee's point of view, even in those communities in which the leading philanthropic organizations have a very good track record of talking to grantees and potential grantees, you might be surprised at some of the perceptions of decisions and how they get made, as well as how you consult with them, pick up ideas, and so forth.

That brings us to the last point, and it is one that sounds purely rhetorical. But we have learned in this city over the last five months how desperately real and desperately true it is. Many of you probably live with this every day, as well. We talk about collaboration and partnership and working well together, but we are not nearly as good at it as we ought to be. This is especially true when, under extraordinary circumstances and under extraordinary stresses, the mechanisms that we thought were assuring very effective partnership and collaboration in the community unravel and fray quickly.

I think real partnership and real collaboration, in any sector, in any part of life, particularly in this society, is a lot harder than we are generally prepared to acknowledge. This is true when we talk about teamwork in the delivery of health care services. For example, when we talk about interdisciplinary teamwork with the support of The John A. Hartford Foundation in the Department of Geriatrics at Mount Sinai, there is sort of an assumption that if people have the right motivation, goodwill, the right degree of support, and some amount of education, they will spontaneously collaborate with one another more readily than they otherwise would.

And that is not true. It takes a lot of work. It takes constant maintenance and sustenance. And I think that is probably true of collaborations among grantmakers, as well as collaborations between grantmakers and other organizations in their communities.

Going forward, we are going to have to start putting much more substance where our rhetoric is about cooperation and collaboration, particularly as we enter an era in which needs are growing substantially faster than our resources.

So to go back over this list, I think we have to rethink our feelings about core support and we have to rethink our feelings about continuing support. We have to rethink our feelings about overhead. We have to learn to be a little more patient, as hard though that may be institutionally, and as countercultural as that may be in contemporary American life. It would be good if we spent a lot more time talking to grantees and potential grantees, and we need to do better at the substance as well as the rhetoric of partnership and collaboration.

Now that is a nice small, narrow agenda that I have provided you. I do that in the recognition that some of it might be potentially controversial but in very strong recognition that we now have two choices. We can start to talk about these things or we can increasingly run the risk of not responding adequately to the challenges we now face.

New Principles of Purchasing Health Care

Ian Morrison

I am a professional futurist. People often ask, how exactly do you become a futurist? My undergraduate training at Edinburgh University was geographic and economic change in Scotland 1580 to 1830. It may seem odd, but it is useful training.

Those of you who know your Scottish history will remember, in a very short period of time in the latter part of the 18th century and beginning of the 19th century, Scotland transformed itself from a bunch of braveheart, claymore-wielding maniacs to being the crucible of the Industrial Revolution and the Age of Enlightenment. As you well know, the Scots invented every important technology over the last 500 years including golf, the steam engine, and television. If you want to fight about that, you can, but you will lose.

In Glasgow, where I grew up, health care is a right; carrying a machine gun is a privilege. Clearly, America got it the wrong way around. The deep irony actually is that the only group of Americans with the right to health care are people who are in prison: three strikes and you are covered.

I moved to Canada in the mid-1970s and did my doctorate in health policy and health economics in Canada, studying with Bob Evans, probably the world's greatest health economist. I am a big fan of the Canadian system. It works for Canadians. It would not work for Americans because you are not Canadian. You do not have the same values. Canadians describe themselves as unarmed Americans with health insurance. There is a significant difference in values which play out in social policy and in the health care system.

What the Future Holds

The goal of futurists is to forecast rather than to predict. Our goal is to help make better decisions in the present by thinking ahead systematically. In doing so, my comments today focus on what I term the new principles of purchasing health care. I want to point out at the outset that I am not advocating these principles, but rather suggesting that they are on the horizon over the next one to three years. They are important in shaping some of the issues that you as foundations will shortly be facing.

To put them in context, I want to start with some sense of why these principles have become important. My comments focus primarily on the private sector, although the challenges you face as grantmakers include both public and private sectors. If you want to influence the public sector in America, you have to get the attention of politicians, and the way you do that is to control the media. So if you can capture *The New York Times* editorial board you are off to the races; you can basically run the government. And if you want to control the private sector in health care, you have to get the attention of the benefit consultants.

The two primary issues from the private sector are cost and quality. The private sector is simply not as interested in access for the broader community. But these principles are going to affect access nonetheless. And that will require your attention.

Cost in the Driver's Seat

The issue of costs is driving the private sector at the moment. We are now seeing the return of health care cost increases. If you go back to the mid-1990s, there was this hiatus where premiums were growing very little underneath the background inflation rate and workers' earnings rate. What we have seen in the last few years is a continuous increase in premiums.

Now there are two reasons why we had that sort of interregnum. One was a competitive managed-care market. It was the peak of growth of managed care. Now the transformation is complete with 91 percent of Americans in managed care in some form.

But the other major effect was that Hillary Clinton scared the American health care system and everybody kept their heads down for two years. My friends in the pharmaceutical industry were wandering around saying, "we are not going to raise our prices over inflation." Most doctors thought they were going to be nationalized a week from Monday so they were somewhat more circumspect in their use of resources. Then, the plan of the Clintonistas blew up, and now we are back to utilization rates that are quite substantial and price increases in many sectors of health care.

I have a partnership with Lou Harris and the School of Public Health at Harvard in which we are surveying employers. These data show employers moved in a short period of time from 1999 when two-thirds of them said their costs were under control to a point in 2001 when two-thirds reported costs were out of control. That is a significant shift in a short period of time.

If you ask, "Do you anticipate that this is going to escalate in the future?" most of the health plan chief executive officers I have talked to believe that we are in double-digit rate increases forever. There are many reasons for this, not the least of which is the power and cost of new technology, including drugs. The best-managed health plans in the country are running somewhere around 15 percent to 16 percent annual compound growth, the worst managed, around 25 percent. Now this is from not even necessarily a very small base, and we could talk about drug costs escalating at that rate. But the Center for Studying Health System Change reported last year that hospital costs, a core element of health care, are also a driving force behind cost increases.

We see these increases, in part, because of the abdication of the health plans in their cost containment role. Managed care was defanged in the last five years and every single health plan is basically backing off of preadmission certification and utilization review. They are throwing up their hands and saying, "we do not want to be the bad guys." So they are searching for new paradigms.

Managed care was supposed to solve all this. But the public has lost confidence in managed care as well as other sectors of the health care industry. When you look at how the public perceives various industries, the computer hardware and software companies are perceived as doing the best job. The reason for this is because of Moore's law. Gordon Moore, the founder of Intel, said 20 years ago that the number of circuits per chip would double every 18 months. That has held true for the last 20 years, it will hold true for the next 20, which means that we are looking at a future with more power than ever before.

Hospitals have slipped a bit, and many hospital CEOs say we are doing relatively well. I point out to them that only 12 percent of Americans were actually admitted to a hospital in a year, so the fact that 67 percent of them think they are doing a good job is not necessarily a stunning endorsement.

Pharmaceutical companies have dropped significantly and are now on the same path of demonization and decline in consumer confidence that the managed-care companies were on in the early 1990s. Managed care now is at a point where it is only one percentage point away from tobacco companies as the most despised in America.

There has been a significant decline in trust in pharmaceuticals over the last couple years. Believe me, the pharmaceutical industry is very concerned, much more concerned than they need to be in some sense because we do not have the stomach to regulate them. But they are fairly paranoid these days about their public image because of the media attention. Remember all the stories that used to be done about the evils of managed care? The journalists have now discovered the drug industry as the bad guys. Now we are reading stories on the excesses of the pharmaceutical industry and they are paranoid as a result.

But demonization is a process that has real consequences, both in terms of public opinion and thus, political action. There would have been no patients' bill of rights had the HMOs not been demonized over the last decade. Similarly, the demonization of the pharmaceutical industry will likely turn into both public policy and private strategy responses. Because in demonizing managed care, in having a patients' bill of rights, what we ended up with were HMOs backing off of tight cost controls and tight networks. Every HMO has open network policies and the future is now about, you can go anywhere you want in American health care, you can go to any specialist, you are just going to have to pay for it. That is the new future that we are heading towards.

Does Quality Equal Choice?

Back in 1995 the public was actually somewhat persuaded that managed care helped quality. Now this is in the wake of the debate on the Clinton health plan and discussion of the value of coordination and integration of care. Some of you may be old enough to remember that period of time. The public actually was somewhat on board in all of that. But in the process of demonization, the lines have crossed over and now, if not a majority, a significant proportion of the American public believes that managed care hurts quality.

As a result, we have arrived at the notion that quality equals choice. The public thinks that rattling around through the yellow pages in search of Marcus Welby is inherently superior to some kind of organized and integrated system of care. There is no evidence to suggest that, though it is certainly a prevailing view. That does not seem to be a very productive way to think about quality because we have, as we all know, significant problems in the delivery of health care services as pointed out in the Institute of Medicine's (IOM) report, *Crossing The Quality Chasm*. The IOM correctly pointed out the need to cultivate the fundamental redesign of health care delivery.

A New System for an Aging Population

Futurists default to two drivers: demographics and technology. We tend to commit what I call premature extrapolation. People assume we have a rapidly aging society. Yet, if you look at the proportion of people over 65 years old, it was about 11 percent or 12 percent in 1980. It is only 13 percent today, and it will be about the same in 2010.

The real problem is in 2022, exactly 20 years from now, when about 20 percent of Americans will be over 65 years old and all of us baby boomers are going to be sitting around in nursing homes singing, "I Got You, Babe" to each other. We are a generation unlike the forgotten few, the greatest generation who were

noble in sacrifice and passive. We are going to want absolutely everything done for us. So it is going to get really ugly in 2022.

The current system of health care financing and delivery is just not going to compute, where you take cranky consumers and extrapolate that out 20 years. So we have 20 years to redesign the system. The problem is we have got to start sometime.

What quality should be about is the systemic application of evidence-based medicine and community health. But let me tell you something, if you travel around the country as I do, the phrase, “evidence-based medicine,” is not embraced wholeheartedly by American doctors. They see evidence-based medicine as one step away from communism. So there is a real difficulty in translating this whole notion of quality as an evidence-based entity to the American medical enterprise.

To turn to doctors for a moment, the 1990s were not a happy time for them. The reason for the doctors in this country and around the world feeling this way is what I call hamster care. We have turned doctors into hamsters on a treadmill of discounted fee for service. They are feeling a bit better now because they feel that managed care is backing off of preadmission certification, utilization review, and micromanagement. They are also somewhat in the ascendant in their bargaining positions with managed care.

Empowerment is Just Another Word for Out-of-Pocket Expense

So that leaves us in a conundrum. The private sector cares about cost and it is concerned about quality. The end result: new principles of purchasing health care based on the big idea of consumer responsibility for payment. When you hear the word empowerment it is code for, “You are on your own, pal.” That is where we are headed.

This new movement of self-directed health plans and defined contribution is not being driven by consumers' desire for control. That is complete nonsense. What the consumer wants is first-dollar coverage paid by someone else. They do not want to be self-directed or empowered to pay out of pocket. This is being foisted on them because we defanged managed care, we do not have another idea, and we do not do government in this country. So there are not many other places to go look.

What is most alarming to me, and what I really want to draw your attention to, is that we are on the edge of a period in American health care where the technical content of care is going to vary much more than it ever has in the past, and will vary based on ability to pay. There have always been distinctions between the uninsured and the insured, but I believe that tiering among the employed, insured population will become profound. That is a challenge for the system.

Conversely, on the provider side — and this is something I actually do support — we are going to see more pay for performance. In other words, there is going to be more tiering, based on the contribution that providers make in terms of improving health status.

All of this will be assisted by e-business processes. That is an important opportunity that should not be overlooked. The Internet is not dead. Dot-coms may be dead, but what we are seeing is e-health has gone from a period of irrational exuberance to irrational pessimism. There is tremendous opportunity for the Internet to be used effectively in making this system work better.

I know I am focusing mostly on health care and mostly on the private sector but I think that left to their own devices these trends are not going to all work out terrifically for the American public. I am deeply concerned that we are going to have to worry about public policy issues such as portability of benefits and community-based risk adjustment.

The health insurance industry privately, if you get in a room with some of their leaders, is deeply concerned that some of these trends we are talking about are going to lead to the unraveling of group health insurance in America. That we could run into an adverse selection death spiral where healthy people move into medical savings accounts and the sick are left behind in insurance pools which will eventually blow up. While this is an extreme prediction, we should worry about the stability of the group insurance market.

Finally, I hope — this is more a plea than a prediction — that it will force us, if we are going down this path of tiering, to confront the issue of universality. Because I think where we are headed, in the best possible way, would be a world of floors and ceilings: a basic floor, a decent floor for all Americans, and the right to trade up with your own money. That to me would be about the best available outcome given you are American, not Canadian. What worries me, however, is that we are not going to have a decent floor for all Americans and that we are going to have this tiering as the answer to solve the employer's problem but it is not going to solve our problems as a society.

Let me just drill down on a couple of these because I think it is important to give you a sense of what is emerging.

Cost Shifting to Employees

The mantra of the moment from the benefit consultants is defined benefit to defined contribution. Now I do not think it is necessarily going to be in the pure form. The purest form of this shift would be to give your employee a pile of cash and the yellow pages and tell them to go fend for themselves. I do not think many employers are going to do that. What they are starting to do is significant cost sharing. Employer surveys are already showing that three-quarters of employers report that they are going to increase the employee premium contribution, increase the cost sharing, and cut spousal benefits.

The mantra in which it is presented by health plans and employers is the requirement that the consumer ought to have “skin in the game.” This is a phrase I have heard over and over again from health plan CEOs and from employers. What it means is that they ought to be paying at the point of care and they ought to be paying in terms of premium. It really reflects what I call the Ross Perot effect.

The Ross Perot effect is based on the premise that you can get Americans to do anything for 10 bucks. Ross Perot spent \$10 a vote. It was not quite enough; he did not get elected. But Michael Bloomberg spent \$90 a vote and he did get elected.

Bottom line, for a \$10 price difference in a tiered formulary situation, you can get enrollees to move to the generics. This effect is happening all over health care. I think you will see every single major health plan offering some kind of tiering of hospital copayments in the next 12 months. Certain plans are proposing to do this for specialty networks. So you have got situations like PacifiCare where cancer patients are paying oncology copayments in the hundreds of dollars.

The January 2003 open enrollment period could see the mother of all cost shifts to employees of large employers, particularly if the thing we call the health insurance misery index continues to operate at a high level. Employers need both the opportunity (high unemployment) and the incentive (rapidly rising health premiums) to actually stick it to their employees. The last time this index was up around 20 percent for a sustained period of time was in the late 1980s and early 1990s. That is when benefits managers were forced to do something about it by chief financial officers and chief executive officers who saw that health care costs were exceeding net profits. That is when there was a massive shift into managed care. We are now back up about the same level and the question is: will employers really stick it to their employees?

I think you are going to see a number of very large plans, including Aetna and Cigna, be quite successful in selling self-directed health plans, defined contribution plans, which are essentially medical savings account and catastrophic coverage, with some prepayment of routine preventive services. These models are going to become quite prevalent in certain sectors, midmarket insurers and some of the small businesses, as well as larger health accounts. In small businesses, where they have been experiencing 40 percent rate increases in some markets, you are going to see a significant rise in the uninsured. We are already picking it up. I am sure many of you are tracking it in your community.

Now there are some positives to this, if it reinforces quality, if it reinforces value, if it reinforces a transformation in the way health care is organized and paid for. But if it is simply an economic solution, there is potential for a backlash as the public says, “hey, this is not what I signed up for; bring back my HMO.” What also worries me greatly is what happens to people of low income who have chronic diseases, because in this scenario, it is not good. We are talking about significant cost sharing being introduced in the drug area, for example, which could raise substantially the out-of-pocket costs of people who have low incomes and chronic disease. And the way this phenomenon will grow rapidly is if we have a bad economy and a Republican administration. You do the math.

New Needs for Navigation

Now we are going to need help in navigation through the system. The more choices you have, the more need for navigational support. There is a certain amount of choice fatigue. I do not know about you, but I get something like 1,500 telephone bills. I do not know why but it is just unbelievable. I can not make sense of it.

There was actually a serious study done by social psychologists and they gave people a choice of 25 Godiva chocolates versus 10 Godiva chocolates, and the people with fewer choices were more satisfied. I think there is a point at which these choices get too complicated for words.

We have an opportunity to navigate people through the system much better than we have done in the past. That is one of the reasons, by the way, we are seeing the rise of what some people call the medical concierge. In the Bay Area where I live and in other communities — Boston, Seattle, Florida — examples have been in the press of physicians basically saying, “Look, I have had enough of this managed-care treadmill. I am going to set up in private practice. All I am going to do is medical concierge.”

Medical concierge is primary care available at the end of e-mail, voice mail, cell phone, any time of the day, to help their rich, affluent clients navigate through the health system. You had better have health insurance over and above the service because if you need to be hospitalized, you are going to have to pay for that separately. They are charging anywhere from \$2,000 to \$4,000 a year for this service.

Now lest any of you have spouses who are physicians and run home and say, "Let's do this, honey," let me advise you that there are not enough rich people to go around. So this is not exactly the answer to the American health care problem. We estimate that probably one-tenth of 1 percent of Americans would be capable of availing themselves of this service.

But the challenge is to provide the kind of medical concierge services, particularly for the chronically ill, that these pilot plans are trying to emulate. Being sick in America is not a pleasant experience in this disintegrated, fee-for-service system, and the need for medical concierge is extreme.

Another trend is customization for the new consumers who are demanding, and skeptical, and want anything, any time, any place. There is no question we baby boomers are in that category and we do want much more consumer responsiveness from our health care. We are highly segmented by lifestyle preferences, by race, by cultural differences, and other consumer segments.

Genomics in the longer run is going to make a requirement for care to be customized. If you are from one of the major states in this country in the South or New York area, you are dealing with populations that are much, much more diverse than in the past. Genomics offers the potential for the right drug for the right patient at the right time.

The question I have is who is going to deliver genomically customized care? Is it going to be done by doctors reading the *Lancet* once every three weeks? I do not think so. It is going to have to be enabled by organized systems that help consumers and physicians identify the appropriate pattern of care. This is a 20-year challenge.

Technology Tiering

Let me just focus for a second on this issue of technology tiering because it is the most troublesome of these new principles: the variation in the technical content of care based on income of the patient. I visited the dentist about a year ago, and the hygienist, who is a forceful young lady, said, "You have deep pockets." And I did not know how she knew that because I thought she was talking financially, which actually was true at the end of the story.

She said, "You have got one tooth where you have a deep pocket. You are going to need this little antimicrobial agent. It is like a little piece of plastic you stick under your gum." I said, "Okay, that is fine." She said, "It is \$43." Lo and behold, at the end of the day you pay the \$43.

This is the beginning of a trend. The five-tier formulary is the leading harbinger. The first two tiers are old generic versus new generic. The difference here is whether the drug companies are still putting a significant amount of marketing dollars behind the generic. The next two important tiers are the rebated versus nonrebated brands.

Now this has got nothing to do with clinical efficacy or outcomes or any of that good scientific stuff. This is good old American cash on the barrelhead. The pharmacy benefit management companies make their money on rebates from the drug companies. So this is about commercial firepower. The decision to be on the formulary or not is based on the negotiations around rebates.

The fifth and final tier is so-called lifestyle drugs like Viagra and Claritin. Now you could say, this is America. You get what you pay for. But we have to worry about what this means for people in Medicare and Medicaid as well as the uninsured. Particularly, what does it mean for low-income working people with marginal health insurance? We have to figure out, from an ethical point of view, how are we going to organize this problem of floors and ceilings for technology.

The argument is that the endpoint used to judge clinical outcomes is a function of the affluence of the individual or the society in which they live. So if you are in Bangladesh, the key outcome you care about is mortality. If you are in the United Kingdom, it is morbidity. If you are in Canada, it is mobility. The French and the Italians are obsessed with their livers and their sexual function, so it is quality of life. And we Americans just want to look good and feel good. We want Viagra, Botox, and Claritin. This is based on a very profound model that my colleague Bob Leitman and I put together many years ago that we call the James Brown and Fernando Lamas effect. We are hoping to win a Nobel prize in economics for this, by the way, which will be amazing since I am a geographer and he is a sociologist.

Changing Incentives for Providers

One of the more positive trends here is the notion of pay-for-performance to providers. This is where there are opportunities for enhancing, improving, and transforming the delivery of health care in America. It will require more attention to better metrics of quality.

We have done some important things on this front, but let's be honest. The average consumer is not sitting up at night waiting for the next release of HEDIS 3.0. That is not what they want. What they want, in my view, is something like a detailed baseball scorecard — when they need an operation, they want to know where to go.

We have got to help, and I think many of you are coming up with ways to provide consumer-friendly information to consumers about how to make choices in this emerging environment. Foundations can play an important role in that because it is not clear to me that there are market-clearing information sources that are coming from either the private sector or from government.

The good news would be that we reward people based on outcomes or some appropriate measures, and maybe there are some intermediate measures that some of the HMOs are using like patient satisfaction or assessments of medical group performance. These are just the early indicators. This is going to get more sophisticated, and we should support it and enhance it.

But let us be careful in remembering that report cards to date, in their embryonic form, as a tool for continuous quality improvement, as a tool for influencing elite purchasers, have been incredibly powerful. But the average punter, as we say in Glasgow, does not use this stuff. Less than 1 percent of people have changed behavior because of a report card.

You have to contrast this with direct-to-consumer advertising from the pharmaceutical industry. Eighty-five percent of Americans have seen a drug ad on TV in the last 12 months and the other 15 percent are in a cave in Kandahar. Thirty percent of them went specifically to their physician to talk about that drug. Half of that 30 percent got a prescription filled. This is the greatest hit rate in the history of advertising and the advertisers will only get better at it. Their media becomes more targeted to people who are likely to take drugs, which tends to be low-income people with chronic diseases.

The Prognosis on E-Health

Now all of this can and should be enabled by e-business processes. These system require infrastructure and this represents an enormous opportunity to make constructive change. After all, two-thirds of Americans are online for health care information.

The Wall Street Journal has reported that the Bush administration is basically going to undo the digital divide stuff that the Clinton administration so cherished. This is unfortunate because the Internet is a tremendous tool for reaching people and it is certainly one in which much can be done. Right now the public uses the Internet for health, but basically to drive themselves to distraction in the middle of the night.

This is a trend we picked up about a year-and-a-half ago. How many of you have used Amazon? Virtually everybody. What happened when you used Amazon? The book turned up, right? You try using the Internet for anything meaningful in health care. Can you make an appointment with your doctor? No. Can you reorder prescriptions? There are just a few isolated cases.

Kaiser, Group Health, and some of the academic medical centers such as Duke are recognizing this, because this is why the consumers were dissatisfied with their use of e-health. Why? Because their expectation is to get the same kind of e-services that they get from Charles Schwab or other people. Smart institutions are figuring this out.

Most importantly we are seeing that physicians are embracing the technology, which is a positive trend for the future. More than 90 percent of doctors are on the Internet. Fully 45 percent of physicians claim to have a web site. Medem, which is the dot-com that was started by the medical societies, reportedly has 80,000 physicians enrolled and operating Web sites. Thirteen percent of doctors claim they are e-mailing patients. I think 11 percent of that 13 percent are lying. Why would they do it? They are not paid for it. I think we have got to change a lot to really enable clinical messaging to happen in other environments apart from Kaiser. I am not worried about Kaiser. They will do fine. It is the other 95 percent of American health care that is of more concern. We are still stuck in limited cyberchondria. We are just using the Internet as the mother of all libraries. We are not doing any transactions with it yet.

In terms of transaction processing, the Medicare Catastrophic Act, which was actually repealed before it was implemented, had an unwitting effect on the pharmacies of America. Every pharmacy got wired. Every pharmacy standardized eligibility verification. So that means that 99 percent of drug claims in America are electronically verified at the point of dispensing. This is fantastic.

We do not do government here. But what we can do is use technology to manage the pluralism that we like to maintain in our system and I think there is a real opportunity there. The Internet is still a backbone and a component in this 20-year redesign of health care. To ignore that I think is to ignore a real opportunity for the future.

Providing a Floor in the New Paradigm

Because we have killed the alternative of private sector management competition, there must be some fundamental attention to public policy issues. Otherwise, things will not work out too well for many folks. Portability and community-based risk adjustment are not exactly issues that the public cares about, but attending to these is necessary in order to maintain the group health insurance system in America. I also think that there is an opportunity to talk honestly about a basic floor for all Americans, although our aspirations in this area are so low now.

I was recently talking to someone with whom I sit on a corporate board and he wanted to know why we still have 40 million uninsured people. I said it is because Ted Kennedy's current political views are to the right of Richard Nixon's in 1970. So we have come a long way on this issue. Still, many of you have done a tremendous job of keeping the uninsured issue in front of the media and in front of policymakers, despite the fact that it is very hard for them to make it news because it has been going on for so long.

The thing I would draw your attention to is the tremendous potential rise in the underinsured in America, particularly amongst the chronically ill of low-income populations in marginal health insurance environments. I think if there is a punch line to what I have tried to say this morning, that is it.

On the health plan side there are really only a few strategies. There is Kaiser, vertically integrating for value. Kaiser is terrific; do not worry about them for the future. But as I say to them, they are a different gig. It is not for all Americans. The doctors are different. The health plan is different. It has its own little culture. I do a lot of work with Kaiser. I love them to death. The good news for Kaiser is, they are the Greek Orthodox Church and California is Greece so they are going to kick butt there. But they should not go east of the Pecos.

The strategy that has worked very effectively is what I call virtual single payer. You get big in a market, you turn doctors into hamsters on a treadmill of discounted fee-for-service. It works terrifically until you get the kind of push back that we have gotten from physicians.

Making a Difference

Where does that take us? I just want to close with what I think are the challenges before you. We are going to see more tiering. It is fine and dandy for overpaid people like us, but it is not going to be fine and dandy if you are a working, uninsured person or if you are a working person with insurance and a chronic illness. This is basically shallow coverage for rising health care costs.

Now there are some positives here. We have talked about consumerization, about improvement in quality, about innovation and delivery. I think everybody has to be attentive to the connection to the local community. Stakeholders ought to be held accountable to local communities.

The biggest challenge is this 20-year redesign of health care financing and delivery in America. There are short-term issues and there are long-term aspirations. You have to be involved in that redesign because nobody else will. There are no politicians who want to take this on. The private sector could care less about a 20-year time horizon. Vision, values, and leadership are very important.

What do I specifically suggest you do about these things I have talked about? I think you ought to be the referees of the emerging tiered health system. You ought to be monitoring and measuring its consequences, the degree to which it is occurring, and the degree to which people are being hurt by it, specifically the underinsured. You have done a great job of the uninsured, but this is much more insidious and is going to be more difficult to track in terms of the consequences.

I think you have to provide infrastructure, even some of the Internet infrastructure that market and government will fail to provide. You are the only people capable of nurturing this very important 20-year transformation of health care financing and delivery. You can make a difference. You have made a difference. You continue to make a difference.

You do not have enough money to solve the problems by direct delivery, but you do have enough money to transform the health care system by leadership. I applaud you for what you have done in the past and what you will do in the future.

Reflections: Looking Back at Lessons Learned

*Steven A. Schroeder
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Steve Schroeder's remarks at the 2002 Annual Meeting drew from his message in The Robert Wood Johnson Foundation's 2001 annual report. We have reprinted that message here with the foundation's permission.

On entering my last year as president of The Robert Wood Johnson Foundation (RWJF), much on my mind are the lessons I've learned about doing the work of philanthropy. Any attempt at distillation is, of course, tempered by my previous experiences working in health care in the United States and overseas, as well as by the knowledge I have gathered over the past 12 years from wise colleagues and counselors. Other observers — including my philanthropic partners at RWJF — may well see things differently. That lack of a standard metric is one of the features that makes our work so challenging, as well as so exhilarating.

I offer the seven lessons that follow, with some advice built around each, in the hope that they will stimulate others to take up the challenge of helping philanthropy achieve its full potential.

Lesson One: Mission Matters

The founding trustees of The Robert Wood Johnson Foundation established a clear and simple mission: “To improve the health and health care of all Americans.” That mission flowed naturally from the original source of our endowment, a fortune derived from a large medical supply and pharmaceutical company, yet allowed a wide choice of philanthropic activity. Over time, the mission has proved both a powerful motivator and a recruiting magnet for staff and trustees. The clarity of our mission often has directed us to the institutionally correct decision.

In 1999, for example, RWJF embarked on a significant programming redirection, one that reflected our concern that the “health” part of our mission was getting short shrift. Our decade's worth of work on the societal impact of tobacco, alcohol, and illicit drugs had amply demonstrated that nonmedical factors were responsible for much suffering and that such factors cause tremendous unnecessary costs to the health care system. Although it was a dramatic shift for us, this change was easy to make because it fit so well with our mission.

Our mission defines who we are, motivates us in our work and directs and informs our expansion efforts. It achieves the right balance between providing focus and giving room for creative interpretation. I have seen other foundations pursue first one, then another program and goal, failing to achieve what they intended because they have not defined clearly where they are headed. If your organization has a powerful mission, exploit it to the fullest extent possible, use it to energize your organization, and keep coming back to it. If your organization does not have a powerful mission, then consider changing it to something you can truly use.

Lesson Two: Focus Is Critical

Grantmakers face an almost irresistible temptation to strike out beyond the boundaries of current grantmaking priorities and explore new territory. It is, in part, a natural reaction to the frustration of working with intractable, chronic issues. In part, it reflects the allure of the new. And, in part, it comes from the understandable impulse of program officers to carve out their own special niches. Yet most experts, and I agree with them, advise having a well-defined focus, to avoid being spread too thin — a rifle, not a shotgun, our first president, David Rogers, used to say.

One way we stay focused is to think specifically about what we won't fund, those roads Robert Frost referred to as "not taken." The foundation's general guidelines include some types of grants we do not make: funding ongoing general operating expenses, basic biomedical research, international programs. Many topics, though important, fall outside the work of our program teams: women's health and occupational health, for example. When staff members are developing specific programs and strategies, we again discuss the kinds of projects that would not be funded under a particular initiative, which helps clarify the logic that our staff have employed in their planning.

The problems most foundations are trying to alleviate are so large that progress will seldom be possible without concentrated efforts. The Robert Wood Johnson Foundation's focus is probably narrower than that of most other large philanthropies, because of the specificity of our mission. Nevertheless, our staff regularly debate whether we have become too diffuse, with our four program goals and 10 program teams. I believe such discussions are essential, here and elsewhere, if grantmakers are to resist the relentless centrifugal forces to which they are subject.

Lesson Three: Execution Trumps Strategy

Foundation staff spend a great deal of time pondering how to approach complex social problems. If they do their homework, they will understand at a minimum what has been tried before, what the evidence shows, what confluence of forces affects the problem and the current thinking of experts, as well as the attitudes of the general public or more targeted constituencies. In the best of worlds, they will then develop a well-designed grantmaking strategy that aligns with the foundation's mission, culture, and resources. But the critical next step is planning that strategy's execution. In my experience, our preoccupation with strategy all too often causes us to gloss over the equally important decisions about the way a goal, or an individual program, will be implemented.

When I first arrived at RWJF, I wanted to harness the foundation's reputation and moral and financial capital to promote specific change strategies. In the years since, I have come to appreciate that leadership and tactics are every bit as important as strategy. Identifying and cultivating individual leaders can be frustrating, because the result isn't, and can't be, totally within our control. The very human qualities of creativity, personality, unpredictability and variability in performance come into play, sometimes for good, sometimes not. Developing effective tactics requires a solid sense of how the world actually works, again a messy science at best, as conditions on the ground change, as progress is made (or not), as midcourse corrections are needed. Sometimes totally extrinsic events, like the September 11th terrorist attacks and their aftermath, can destabilize efforts that were previously on course.

Foundations, including RWJF, tend to overemphasize strategy at the expense of execution because of internal reward structures, because of our relative isolation from the front lines, and because we typically recruit staff whose backgrounds are stronger in conceptualization than in operations. Common mistakes in planning for the implementation of a program include selecting the wrong leader, permitting lines of authority between foundation staff and the program director to become tangled, missing opportunities to communicate about the program, and having unrealistic expectations that set grantees up to fail.

Achieving a proper balance between strategic design and implementation requires that we address each of these factors by shifting internal reward structures, staying more in tune with what is happening in the broad environment, and looking for staff who are strong in both strategy and execution. All of these are easier said than done, but at the end of the day, what matters is the strength and usefulness of what has been built, not how elegant was the blueprint.

Lesson Four: Social Change Comes Hard

The kinds of social problems that RWJF and many other foundations tackle are the “big, hairy, audacious” ones. Typically, they are problems with significant consequences and multiple causes and contributors. If they were easy, they would have been solved already. The example that comes immediately to mind is poverty, a problem many foundations address with energy and creativity, even though its intractability was recognized 2,000 years ago (For ye have the poor always with you, Matthew 26:11).

Increasing health insurance coverage, reducing smoking rates, and improving end-of-life care are three areas where RWJF has worked extensively in the past decade, and in which we believe we have contributed to notable progress. Nevertheless, in each of these fields the problems have deep roots in many social, psychological, policy, and practice domains and are far from being solved in any comprehensive or permanent way.

Recognizing that it will be difficult to achieve the scale of social change that would completely solve problems such as these, foundations still want to know whether their efforts are relevant and successful in moving us partway. How do we know how much we have accomplished? Sometimes the choice seems to be between picking easy targets to measure and finding proxy measures for social change, neither of which may give a satisfactory status report. And, sometimes, we must decide that an avenue is worth pursuing even though our progress measures are not sensitive enough to guide us. Even without adequate guideposts, foundations addressing these kinds of complex problems must be prepared to take the long view. They must ask whether they can give themselves both the nourishment of optimism and a dose of realism when facing agonizingly slow progress, and whether they can sustain themselves in the face of persistent obstacles.

My bottom line for foundations that choose to tackle problems that require social change is that we must recognize the significance of the extra burden such problems place on our staff and institution. Still, I believe that in making the attempt we fulfill one of philanthropy's essential roles in society.

Lesson Five: Know When to Hold 'em, Know When to Fold 'em

Knowing how long to stay with a particular goal, strategy, grantee or program leader is part of the art of philanthropy. My colleague Terrance Keenan advises that the willingness to stick with a set of issues over a prolonged period is a distinguishing quality of foundations that “really make a difference.”

We have a natural suspicion of staying too long in a particular field, pouring good money after bad, becoming unduly enamored of a favored set of grantees, pushing lost causes, or creating undue grantee dependence. At the same time, we recognize the risks of getting out of an area too early, perhaps just short of the tipping point, as well as the symbolic import of exiting a field, particularly for a large foundation like ours. The trick is in the timing. In my tenure we've made both errors, staying too long in some arenas and getting out too early in others.

Here's an example of where we avoided those pitfalls. Among RWJF's strongest programs, we believe, is the Local Initiative Funding Partners Program. This program works in partnership with local grantmakers to provide matching grants to innovative community-based projects for underserved and at-risk people. It didn't start out as such a success; in fact, it had some serious problems. But rather than abandoning it, we made some necessary changes. Now it has made almost 200 grants totaling \$63 million and has helped establish good relationships with funders nationwide as well as numerous grassroots organizations.

No one can recommend specifically when a foundation should fold its hand and get up from the table. What I can offer are two bits of wisdom gleaned from the past 12 years:

- C Leave the table carefully. Foundations generally exit too soon rather than too late.
- C Keep questioning and debating, internally and externally. It is the only way to know for sure when it is time to move on.

Lesson Six: Establish a Strong Internal Culture

When I came to the foundation in 1990, I told our staff that my aspirations were simple: “Best possible programs, best possible place to work.” Implicit in that formulation was the hope that these two goals would reinforce each other.

In a small philanthropy it may be possible for a single leader to drive program development, leaving to the staff the day-to-day functions of execution and monitoring. A foundation of our size, however, relies on the creativity and passion of its staff to design programs and oversee their implementation. We must recruit and retain the best possible people for this complex job and establish working conditions that allow them to flourish. Because it is almost as hard to assess individual accomplishment as it is to measure foundation performance overall, subtle incentives and institutional rewards take on heightened importance.

The combination of ambitious goals and ambiguous performance measures can create a permanent undertow of anxiety among a foundation's staff, who worry that they are not doing enough. Staff also may feel a bit guilty when they compare their own relative economic security with the turbulence faced by friends and colleagues working in industry, government, and nonprofit organizations.

The key is to build a culture that will reinforce mission, stimulate and reward performance, and help with recruitment and retention. It remains important, as well, to give staff opportunities to help make the foundation a better place to work. At RWJF, we have instituted a multidirectional performance feedback system for managers, who are now assessed by people above, below, and alongside themselves on the organizational chart. We encourage formal and informal staff development through mentoring, leadership

development, and individual coaching. And we are preparing for our second survey, in which staff can anonymously assess the foundation's culture and management. The previous survey revealed some significant opportunities for management improvement that we moved quickly to address.

To accomplish all of this requires holding certain principles dear: treating staff with respect and dignity and making sure they know they are expected to treat grantees and applicants the same way; maintaining integrity of purpose and conduct; avoiding ostentation; undertaking a relentless internal quality improvement program for staff and for organizational processes; and instituting regular feedback about organizational and individual performance and goals, involving both internal colleagues and external constituencies. I would also recommend sprinkling in a little humor; philanthropy sometimes takes itself too seriously, and its ambassadors can appear self-important.

Lesson Seven: Pursue Accountability

Accountability, we believe, requires letting the world know the results of our grantmaking in depth, in ways that can be acted upon. As with any enterprise, foundations need to know if they are making a difference. The question is rarely whether to measure success; it is more often what to measure and how. Foundations lack the usual yardsticks of success used in business, government or academia. No financial bottom line, periodic election returns, or *U.S. News & World Report* rankings exist against which to calibrate our performance.

Collectively, foundations vary greatly in missions, goals and strategies; the scope, scale and nature of the grants we make; the time frames of our grantmaking; and the degree to which our contributions are even identifiable. Though I have enjoyed reading the occasional reports on the large foundations that are written by professional foundation-watchers (and they have generally been kind to RWJF), they are highly subjective and their methods are not reproducible.

At RWJF, we have spent a great deal of time and energy developing and pursuing three interrelated approaches to assessing how we are doing: evaluations, performance measurements, and public disclosure. Independent, external evaluations of RWJF national programs and some major grants, conducted by some of the health care field's leading researchers, have long been a hallmark of this organization. In recent years we have developed a variety of internal performance measures — including development and assessment of strategic objectives within our program interest areas and periodic formal and informal assessment of how we are doing as judged by important audiences — with the intent of integrating the results and feeding them back into future grantmaking. We spend an increasingly large proportion of our quarterly Board of Trustees meetings wrestling with how to measure the impact of our proposed and existing programs.

Some of our pioneering efforts, in my view, lie in the realm of public disclosure — for example, our reports on grant results and the essays in the annual RWJF anthology, *To Improve Health and Health Care*. Our growing library of 600 grant results reports (available online at www.rwjf.org) looks carefully at what was accomplished by the scores of grants made each year. The anthology — available online and in paperback — attempts to provide a critical, in-depth review of individual foundation programs, grantmaking approaches and impacts on specific fields. In terms of traditional evaluation, we have committed almost \$20 million to new program evaluation in 2001, and we have some \$56 million in evaluations ongoing from this and prior years.

Despite these efforts, our quest for performance measurement remains incomplete. In part this is because it is so difficult to establish causality when we are working on complex social issues, often alongside many others. For example, during the past decade we have invested heavily in programs to reduce the number of Americans who lack health insurance. Despite our efforts, the number of uninsured has resumed its upward

climb. Should we accept some blame for that lack of progress? Did our efforts prevent worse outcomes? How can we know?

We also sometimes make our job harder by not specifying up front exactly what we hope to achieve with a particular grant, program, or grantmaking strategy. Sometimes we oversell what we hope to accomplish, because we believe in it and because we want the support of our colleagues. Sometimes we are tempted to tackle trivial problems where we know we can measure our results. I like to think that's a temptation we usually resist.

The widely disparate strategies we employ defy ready comparison. For example, seeing the results of our efforts in leadership development takes years, if not decades, as compared to the next-day results we can obtain from a poll on a topical issue. While the latter may help us or others shape a short-term action, design a program or make a policy decision, the former contributes in some way to the development of people who will assume important leadership positions some 20 years hence. Despite these difficulties, we in philanthropy owe it to ourselves, our constituencies and the fields in which we work to try as hard as possible to judge the worth of what we do. We must not abandon attempts at assessment because the tools are crude. I have watched RWJF get better and better at evaluation over the past decade, and I know this essential struggle will continue.

Conclusion

Serving as president of The Robert Wood Johnson Foundation for the past dozen years has been a privilege, I recognize, and a rare one. The combination of abundant resources, a supportive board of trustees, a talented and dedicated staff, and creative, hardworking grantees has made it a pleasure to come to work each morning. To be sure, the problems we have tried to address are daunting. We often feel more like Sisyphus than Sir Edmund Hillary. Still, we remain enthusiastic and committed, because of our mission, our focus, our realism and our culture. So it is that, when reviewing one of our program areas, I often find myself rephrasing Robert Browning, "Ah, but a foundation's reach should exceed its grasp, Or what's a heaven for?"

Even better, I like to think that our arms are getting just a little longer, day by day.

The Public Health Lessons and Needs of September 11th

*Martha Katz
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I was asked to speak this morning on the current state of public health, and its implications for health philanthropy. Needless to say, the events of the fall of 2001 offer a new perspective on the current state of public health. I would like to reflect on some of the implications of the attacks from anthrax and the attacks on the World Trade Center and the Pentagon on our programs and our priorities.

As many of you know, the Centers for Disease Control and Prevention (CDC) must focus on the full range of preventable health problems we are experiencing in the 21st century: infectious disease, chronic disease, environmental and occupational health problems, injuries, maternal and child health, and health statistics. But by 9:00 am on September 11th, we, like the rest of the country, narrowed our focus. Last night was the first time I have flown into New York City since September 11th and thinking back, emblazoned in my mind are the images that we all saw on television that day but also the images of the response unfolding in Atlanta.

We ended up actually having to evacuate our Atlanta headquarters on Clifton Road, and moving to our Chamblee facility, which sits next to a small airfield, the Peachtree-DeKalb Airport. And usually, when we have meetings in that building, the sound of airplanes taking off every couple of minutes drones in the background. It was deathly silent that day.

About 4:30 in the afternoon, the silence from the airport was broken and one of the few private airplanes that took off that day in this country flew with a group of eight CDC staff members and the National Pharmaceutical stockpile to New York City. The stockpile had been activated for the first time ever about a half hour earlier.

The staff took incredible pictures from the windows of the airplane. Reflecting later, they told me that it was a moment when they felt quite fortunate to be able to actually do something to respond. They felt both reassured and totally uncomfortable when two F-15 fighter planes accompanied them into LaGuardia Airport.

As you can tell, I still get emotional about these events because it was a tremendous responsibility to figure out what we could do to help.

Needless to say, by the first week of October, our efforts shifted not just from terrorism response but to bioterrorism. With the first cases in Florida and eventually cases of anthrax in five different locations around the country, we were deploying people day and night. Eventually, 500 staff went into the field. More than 1,000 people from CDC were involved in the emergency response center, in the science, in the laboratory, in figuring out what type of expertise we needed to make us most able to respond quickly to these attacks.

Eventually, we involved laboratory scientists, epidemiologist, experts in clinical care and in communications, and health educators. When it came time for cleanup of the buildings, our environmental and occupational health specialists and industrial hygienists took the lead. Every dimension in public health was called on to rise to the occasion.

A Nationwide Response

This response was going on in every single city, county, and state in the nation. There may have been five places affected, but everybody was affected. Every city, county and state was put on alert for disease surveillance on September 11th and they are still on high alert. Every city, county, and state has tested a lot of white powder.

In fact, the health officer from Mississippi said, “Martha, you don't understand, they are bringing us five-pound sacks of flour to test. We need some quick testing methods here.” Everyone has been using their information systems to the hilt and every city, county, and state has communicated directly and constantly with a concerned community.

But here lies some of the questions that lead us to reflect about what this means for the future. What does it mean to be prepared? For what do we need to be prepared? All of us have read the newspapers and we have heard the most incredible examples, because everyone can dream of his or her worst horror story.

In fact, between September and December, I got to the point that I did not want to hear people's worst fantasies anymore because their worst fantasies are far beyond the capabilities of public health for response and for preparedness, not just at CDC but at public health departments throughout the country.

We are struggling with how to balance emergency preparedness with our common daily health concerns. We know that the fear of bioterrorism, and of all kinds of terrorism, is very high. Yes, five people died from anthrax. But 2 million people die every year, and most of them are dying from chronic diseases and injuries. So how do we balance dealing with anthrax in the mail with hospitalization for diabetes? How do we balance the need for an investment in vaccine development and production for potential bioterrorist threats with that for flu and pneumococcal pneumonia?

We struggle with the issue of how to sell people on the value of prevention versus curative medicine. It is the old debate from the Greek goddesses of Hygeia and Panacea. It is an important balance, and how we achieve that will shape our future.

How do we deal with the compelling needs of an ill person with the amorphous needs of our whole population? How do we look at long-term improvements versus immediate results? And how do we balance the demand for high-tech devices with the true public health infrastructure, which is a lot less glamorous and very difficult to sell?

The huge interest in bioterrorism raises all of these issues, but has also positioned us better than ever to look at how we build a strong public health system throughout this country. We have people talking about public health who never thought about it before. We have people who have seen the

leadership of the New York City Health Department, and of health departments in Connecticut, Florida, Washington, DC, and New Jersey. They saw what happened in their own communities. They now have a far better understanding of the role of people in epidemiology, in surveillance, in communications systems, and in health education. They are concerned about the link between clinical care and public health in a way that people never before have been.

Eight Areas of Improvement

Now at the risk of being presumptuous, I would like to delineate eight areas where I think health grantmakers can provide greater leadership for this country. The first one is in the area of community leadership. Although CDC just made grants of almost \$1 billion for bioterrorism and public health preparedness, we all know that money alone is not the solution for building state and local capacities. We need people at the community level, people such as you, who have the power to convene people who make a difference: decisionmakers, elected officials, and business leaders. All of them need to be brought to the table to work with their public health leaders, with their state health department leaders, and those local health department directors to plan for the future.

This is important because the way we engage the different sectors from the beginning is going to have a great influence on how this money is spent. It is not enough for us to have people looking at these issues. They need to be actively engaged. Every state and every community is looking at the effect of the changes in the economy. And those of you who are reading your local newspapers know that your governors are wringing their hands over how they are going to balance their state budgets. They cannot balance the budget with the public health preparedness dollars. And you need to be in the forefront with public health leaders to make sure that does not happen.

Secondly, we need to make sure that preparedness is preparedness for all hazards and emergencies, and preparedness for the true health problems of our time, not simply bioterrorism. We will have failed to serve the public if the systems we build for bioterrorism cannot handle West Nile Virus. Look at the epidemiology. The West Nile Virus is no longer limited to New York City and New Jersey. It was in 27 different states last year and is moving toward Wyoming and Montana. The West Nile Virus is no longer unique to the East Coast.

We will have failed if we cannot address pandemic flu or dengue fever or a chemical disaster. We will have failed if state and local health departments cannot deal with chronic diseases and injuries. We must build systems with people at the local level to serve all public health needs. These systems should be able to deal with tobacco control, surveillance, and epidemiology.

The third area is communications. I think that many of us have gone into positions in government and the nonprofit sector because we want to serve people. It is a value that we all share. It is one shared by elected officials. And it is a value shared by members of your boards of directors. The single most important lessons of the anthrax experience is that clear communication is essential. We need to be able to communicate with people who are directly at risk such as postal workers, with policymakers, with the press, as well as with the general public because we learned that there was an almost insatiable appetite for the public to learn more about what was happening.

Now the research that was conducted by Robert Blendon, at Harvard University, supported by The Robert Wood Johnson Foundation, has helped us. It answered the questions that have been most urgent for me in my role at CDC in the last six months. He asked the American public how they responded to terrorism. And the answers that he received are instructive. They also give us a clue as to some of the questions that you need to ask at the local level.

He learned that the public understood that they were more likely to get the flu, to be injured in a car, to be injured in a fall, or to have cancer than they were to be exposed to anthrax. The American people are smart.

He asked them whom they trust. I can tell you that the answer is the most trusted person in a bioterrorism event in this country is the director of CDC. They rely on CDC for trusted, reliable health information.

But locally, which is even more important, they trust people who you might not imagine. I have had many planning sessions where people have told me that in case of an emergency, the governor will be the spokesperson for the state, or the mayor will be the spokesperson for the city. But communications research tells us that messages should be relayed by the people the public trusts, not who we think they should trust.

In the city of Atlanta, I can tell you that if we had a major emergency and I was responsible for picking a spokesperson, I might choose Andrew Young, former mayor and former U.S. representative to the United Nations, a man whom everyone in the city knows, and has seen rise to different occasions. That would be my choice. But in every city there are different people who are the opinion leaders. In many communities, the person people trust the most is their doctor and the public officials they trust is the fireman, the true rescue worker. The next person is the health department director.

Health philanthropies can help create these channels of communications, remembering that part of preparedness is knowing how we are going to communicate.

The fourth area is to bridge the gap between public health and medical care. These are two different worlds. In investigating the 18 cases of anthrax (as well as dozens of other suspected cases), one of the things that worked well is that we sent out a clinician on every one of those investigative teams. These physicians looked at the nature of the care provided to the people who were ill. They looked at the history and knew that the mortality rate was far greater than 50 percent. And they knew that if they did not look at the improvements in care, take lessons from one case to another, and develop new recommendations, we were going to lose most of those 18 cases. In fact, we only had five deaths. And I give these young clinicians credit for bridging the gap between clinical care and public health.

What is needed are systems at the community level that create the communication from clinical care to public health. It was a doctor in Florida who saw the first case of anthrax. He was the one who needed to know what he was looking for, and he had fortunately a trusted relationship with the Palm Beach County Health Department. So that he told them what he was looking at and they were able to call us. And among us we were able to do the laboratory work to confirm that it was anthrax.

We had our first major teleconference for clinicians in the middle of October, reaching hundreds of thousands of clinicians around the country with what they needed to know to look for in anthrax

cases. We redesigned our Web site for bioterrorism so that physicians and nurses can more easily find the information they need.

But we need your help. You must build the systems at the local level so that your local hospitals, local doctors, local public health officials, and people in your states are connected with each other so that they work not only on bioterrorism but also on a range of public health problems.

Fifth, we need to keep the daily health challenges on the radar screen. When we look at chronic diseases and we look at aging and the aging of the U.S. population, we know that these will be important issues well into our future. We will have to redesign communities, to make them more livable in order to deal with obesity, nutrition, and physical activity. I live in the only neighborhood in Atlanta where I can walk to a grocery store, a drug store, dozens of restaurants, a gymnasium, and a marvelous park. Everyone should be able to live in a walkable community.

Creating relationships with real estate developers and finding new ways to design livable communities are just as important as emergency preparedness. And we need to keep those issues, as well as gaps in health care coverage, all on the radar screen.

The sixth area is evaluation. You can be instrumental in helping state and local health agencies find the measurable outcomes that are needed to show their program's success. The grants to states have been out less than 10 days. What we did, which is very unusual, is we told every state how much money they would be getting before we asked for their grant applications in an effort to speed up the availability of money. We are allowing states to spend 20 percent of it first, even before they submit their grant applications.

The grant application seminars have been held and I already have received phone calls asking me how we are going to know whether or not the states are doing what we asked them to do. Do we have our systems of accountability in place already? Do we know whether or not in six months we will have measurable results?

These are high expectations for evaluation and we are not going to be able to do this by ourselves. You have great expertise and evaluation — if you do not have it in-house, you have access to it. Your state health officials are going to need your assistance in designing, tracking and evaluation systems. The sooner you can get in there and help them the better, because there will not be a sustained commitment to building the public health capacity in this country if we cannot show people that their money is being well spent and give them the motivation to sustain their commitment.

Social equity is number seven. We cannot have preparedness only for the well-to-do. When I look back at Bob Blendon's research, he asked two questions among many others that are quite striking to me. He asked how many people bought gas masks? One percent did. He asked how many people sought and got prescriptions for antibiotics? Five percent of the people he surveyed did.

Now I have been fitted for a gas mask. Let me tell you, you do not want one in your closet. You are not going to want to wear it, and you are not going to be able to breathe after you put it on. They are very hard to breathe through. But these are things that only people of means can afford to buy.

Our response for bioterrorism and for public health emergencies must be socially equitable. It is a basic tenet of public health and it is certainly a basic tenet for health philanthropy that we provide the greatest good for the most people. Being able to build our preparedness systems in a way that serves the whole population is exactly what we need to do. We need your help in assuring that will happen when the decisions get made.

Last but not least, this is an opportunity for us to recognize that our national health problems are global health problems. We know, just as New Yorkers know, that we live in a global community. My cab driver here was from Romania. He has lived here for 20 years but he has spent the last four summers in Romania. If you live in a state that is along the U.S.-Mexico border, you know that health problems have no boundaries. If you examine tobacco control, you know that is a global health issue. If you work in infectious disease control, it is very obvious that infectious diseases travel quickly among different countries.

Many of us have domestic agendas. CDC is very much a national agency with a strong domestic agenda. But we have learned and we have grown our programs in global health because we cannot be successful with what we do in this country if we are not working with our global partners.

Building Capacities On All Levels

What we have learned since September 11th is that there is nothing more important than the reality that we need one another. Overcoming terrorism and dealing with the broad range of public health problems that face us means that we cannot look at things with the mentality of either/or. It can only be realized when we think and act in terms of “and.” It is not working at the national level or the state level or the local level. It is local, state and national working together. It is not public agencies or the philanthropic sector, it is public agencies and philanthropy working together. It is not Kansas working by itself. It is Kansas working with its neighbors in Oklahoma and Missouri. It is not simply one sector in health working alone. It is working with law enforcement, with education, with social services. It is bringing public health together.

The only way that we will achieve a higher level of preparedness in the United States is if we have leaders demonstrating their commitment to working together without concern for who gets the credit. It is the only formula for success in our effort to improve people's health and safety, in this country and throughout the world.

Rewriting a Foundation's Message: Taking Risks, Inspiring Trust, Exercising Power

Tony Proscio

Back in 1960, when the Central Intelligence Agency (CIA) launched its legendary campaign to kill Fidel Castro — an adventure that left Castro completely unscathed — the director of the CIA, Allen Dulles, convened an elite team of chemists to concoct a poison that could be slipped into el Jefe's rum and Coke. They had a sense of poetry in the Eisenhower administration. A rum and Coke is, in this country at least, commonly known as a Cuba Libre.

It did not have that effect, however, as we know. But while they were trying, Allen Dulles dubbed this secret group of scientists in the technical services division of the CIA as, “The Health Alteration Committee.”

I think of Allen Dulles nowadays whenever I see some foundation declaring that it is going to improve the health outcomes of some favored group of people. I find the phrase a little hard to pin down. I assume it does not mean anything quite as final as what Allen Dulles meant by “health alteration.” But I am not sure exactly what it does mean. And while I am pretty sure many grantmakers could tell me for certain what the phrase means, I would be willing to bet that each would tell me something slightly different.

The words themselves do not really tell me very much. The sad truth is that, with the possible exception of Fidel Castro, all of us are going to have pretty much the same health outcome sooner or later. And those of you who had the three-egg omelet for breakfast will have it a little sooner than the rest of us. But “health outcomes” is one of those phrases that says to me we are dancing around the issue, we are not addressing it forthrightly.

I bring this up because what I consider vague talk about health outcomes is a good illustration of the three themes that I would like to explore: risk, trust, and power. It seems to me that the way a foundation approaches these three issues will determine to a considerable degree the kind of relationship that it has with its grantees and other important players in its fields, and the influence it is likely to exert over that field as a whole.

I think it is fair to say that nowhere are these three issues more central than in the field of health. The risks are literally life-and-death. The field is diffuse and not well integrated, so key players can't work together without a significant degree of trust. And at least as much as in any other part of philanthropy, funding equates to power over research and treatment and advocacy.

And all three of these issues, it seems to me, are reflected in the way an institution talks about itself and the way it talks to other people. Our purpose today is going to be to think through the relationships that foundations form with their grantees and whether those relationships lead to better results.

Taking an Honest Look at the Message

My particular window for looking at this issue is one of language and message and voice. I am a consultant to foundations, not always about language and communication, often about management. But my credentials lie mainly in helping foundations think through what they do, what they are trying to accomplish, and how successful they think they have been or how they will recognize success if and when they see it.

It is remarkable to me, in doing that kind of work, how often foundations and their grantees express all of those things in different ways, sometimes in contradictory ways. And they will even say, behind cupped hands, that the other side is not really on the same team or doing the same things the same way that we are. This is normal business in American philanthropy. We are not all on the same team, we know it most of the time, and too often we are not at all disturbed by the fact.

All these questions about unclear and conflicting purposes inevitably force my clients, when they raise and confront them honestly, to look both at themselves and at their field through the prisms of risk and trust and power: the risks they take as they pursue their goals, the trust they desire and earn or fail to earn from grantees, and the power they inevitably wield.

Often foundations find that the actual level of these three things is quite different from what they admit, even to themselves but certainly to others. And it is very different from what they imply in their speaking and writing.

Taking a Risk

Let me take each issue one at a time. Let's start with risk. I think it is a safe statement, almost a tautology, that the importance of any foundation activity is directly proportional to the amount of risk that activity entails. Conversely, the easier it is to get something done, the less likely it is that doing it will make a big difference.

So foundations at their best, and I think that is most of the time, occupy a position of very high risk in the world of public policy and social problems. But gauging that risk is not easy. In the business world, you know exactly what the risks are. They are measured in financial losses and in the odds of bankruptcy on any given day.

But in the foundation world, financial losses *are* the business. Parting with money is what you do. So you have the luxury — not necessarily one you want, but you have it — of being able to keep the risks under the rug. They are not easily reckoned. They are not always mathematically certain. And that is dangerous.

It leads many people into the easy temptation of making their work seem safe and assured, winning friends largely by papering over the risks.

To see what I mean take a look at this. This was actually submitted to some helpless, unwitting board of trustees about that mainstay of all philanthropic activity, a *partnership*.

"The partnership has created a flexible action-oriented and thoughtful governance structure to allow it to work nimbly with its partners and other organizations and intermediaries to coordinate the partnership's activities and impact upon the target population."

I love this kind of thing. This is what makes my job worthwhile. I particularly like "nimbly". It sits there kind of like a diamond in a dime store. It is one little sparkle in a slough of kitsch. But what does this thing say really?

What this is meant to say is: We have got a simply terrific partnership here, and there really is no problem with it, so please just go ahead and approve it; no questions, please.

But between the lines — and we have all seen and written things like this, we know what lies behind this statement. I am speculating here, but it looks to me like this partnership has got to maintain a whole galaxy of good relations with other people, all of whom probably have their own agendas. And notice: Things are so complicated in this thing that the partnership even has partners.

In other words, this is probably a very risky undertaking. It may be highly worthwhile, but it is being presented here as if it were all so elegantly arranged, so completely in order, that it has driven the evil hand of entropy straight out of the laws of thermodynamics. All quite tidy, nothing to fear.

Now my point, understand, is not that foundations do not accept risks or that they do not recognize them. My sense, particularly in the more scientific fields such as the one you work in, is that program officers are at least as sophisticated as everybody else, and usually more so, about the times when they are getting into the tall grass. They sometimes embrace a subject, at their best, *precisely* because it is too risky for the private sector or other organized interests to take a hand in it.

So my point is not that foundations don't know risk. It's that they hate to own up to it and they do everything they can to cover it up. To most foundations, in my experience, the most unmentionable risk of all is not the risk of failure, which you confront routinely, but the risk of controversy.

I want to read to you — with some apology for a longish recitation here — a note that I got from the head of a big nonprofit organization shortly after my first essay about jargon was published. This person is a friend of mine, but he was not all that keen on my essay. He felt that I gave the foundation world too much credit. This is what he wrote to me:

"Most writing in foundations seems to me to be directed to supervisors and trustees and occasionally to colleagues in other foundations. It is a functional, not intellectual product. And the people doing this writing are extremely nervous about what their rather narrow audience might think. That is why they spend so much time rewriting the proposals that they are recommending for funding."

"I still recall my surprise 12 years ago when I realized that the proposals I wrote as a potential grantee never made it to the board's agreeing to fund them. Foundation staff explained to me then that they needed to prepare shorter summaries for their boards. But that explanation never really satisfied. It would, after all, be easy enough to ask grantees to write their own summaries as part of their applications."

“What is really happening, is that program officers are restating the proposals to eliminate controversy, and sometimes to exaggerate the contribution of the foundation.”

What he seems to be saying here is that in his experience, foundations want to have it both ways. They want to bury any suggestion of political or ideological danger, but if everything comes out smoothly and everyone is happy, then it was our idea.

I do not think, and I have substantial experience to back me up, that his criticism is fair. I don't think it's accurate. But the fact that it's what he believes — and that he is, in my experience, not at all alone in that belief — is a significant part of the problem. The extent to which foundations embrace and share and are even drawn to risk is not as well appreciated by grantees as it could or should be.

It is certainly true that foundations, in their public statements, do everything they can to smooth over what they actually do, and in many cases paint as gauzy and soothing a picture as possible of tough, controversial programs.

Here is an example from a basic public information piece, a sort of introductory publication, about a major national foundation.

“The foundation identifies and supports leaders, institutions, and organizations dedicated to learning, knowledge building and solving pressing social problems through programs and projects that value voluntary service, philanthropic giving, scholarship, and research.”

Now this is their capsule summary of what they do. This is their introduction to the world. The truth is, this foundation has four very specific program areas. They will not make a nickel's worth of grants outside those four areas. They are very focused and very strategic.

But look at the statement. Now judging from that, what does this foundation not do? What do they not fund? Take one example: Would they give a grant to Microsoft? Probably not. But Microsoft is certainly an institution dedicated to knowledge building and solving pressing social problems through programs and projects that value scholarship and research. In fact, if you include their corporate philanthropy, they emphasize voluntary service and philanthropic giving, too.

This foundation's statement is meant to avoid offending, excluding, or limiting anyone or anything. In the process, it casts its net over all the living and the dead. Who is not in here? The Mafia, maybe. A couple of survivalist camps in Montana. Everybody in this room could get a grant under this statement.

We will come back to the question of what is excluded in a minute, but I think it is really important to emphasize one more time that this is the *first sentence* in the foundation's brochure. It is its first step into the world of public discussion. Make no choices, alienate no one, take no visible risks.

A friend of mine who was once a press secretary to a famously risk-taking governor said to me once that in the world of real public policy, the crucial question for communicating any public policy goal is: *What are you against?* It sounds cynical, he said, but it is actually just the opposite. If you tell me somebody is tall, I want to know compared to whom. Tell me something is dark, I want to know

compared to what. At least in a democracy, when you tell me something is wise or worthwhile or important, I need to know compared to what else I could be supporting.

This is how he summed it up: If you are so afraid of offending me that you will not make any comparisons, then you are probably too timid to convince me, and you just may make me suspicious in the bargain.

So in the example we read before, what was that foundation *against*? Could you have read that statement and say, *compared to what*? I am being very harsh, by the way, on what I can promise you is one of the best foundations in this country. It is no reflection on what they do or how they do it.

The point is, you may take risks. You may, and probably do, lose sleep at night over the risks you're embracing. And you may face formidable opposition over every important thing you do. But you will be perceived by a skeptical public as marginal and timid if you go to those kinds of lengths to keep the reality of your risks out of the public discussion.

Grantees obviously do not have any such luxury. If you are actually housing the mentally ill or treating heroin addicts or counseling rural teenagers with HIV, there is no way to paper over the risks that you're taking or the controversy that you are likely to encounter. There are no fig leaves for action, but there is a convenient curtain for the *funding* of that action and, although grantmakers in my experience rarely seek out that kind of protection, it is always there for them.

Inspiring Trust in Partnerships

This takes us from the matter of risk to my second topic, which is trust. An effective relationship with grantees — what more and more foundations insist on calling “partnering” — is only as real as the honesty and trust that exists between the two parties.

There are lots of important components to an effective partnership. But one of them, probably not sufficient and yet irreducibly necessary, is trust. And it is often the one that is the most lacking.

One reason, which I have just mentioned, is that grantees do not feel that they face the same kind of risks that their funders do. Whether that belief is fair or not is somewhat beside the point. It is what many of them believe.

Trust, in a relationship with a funder, would mean that a grantee would be able to say, “Some of our staff are not as able as they ought to be, and we either ought to train them or replace them.” A grantee that trusts a funder would be able to say, “Our financial control systems are not what we need, and maybe you could help us improve them.” Or they would say, “Last year's efforts were a real disappointment, and we need to completely rethink our program model. Could you help us with a planning grant?” That happens very rarely.

One of the reasons it happens so rarely is that foundations rarely say those things about themselves, at least to grantees. When was the last time you heard a foundation say, even privately, “That whole initiative was a big mistake?”

Here is a statement about a foundation program that involved dozens of grantees all over the country. I think this helps illustrate why it is so hard so much of the time to let your hair down in a conversation with a foundation.

“This program worked to improve the capacity of state health systems to support health policymaking and program management, funded projects, assessed state's health policy needs, established plans and set priorities to meet those needs and improve the state's health statistics infrastructure.”

That is not a particularly felicitously written thing, but that isn't my point. My point is that trust is a relationship between *people*. People earn it, people exchange it, people rely on other people to determine when and where to put their trust. Few of us trust disembodied institutions, except with respect to the people in those institutions.

About 20 years ago, at the first board meeting of what was then a brand new nonprofit organization that made loans for community development, one of the young staff members — it may well have been me — was presenting a complicated loan proposal. These things ran to 20 or 30 pages, lots of appendices, ratio analyses, spreadsheets and so on. The presentation was droning on and on, as young people are sometimes prone to do in those situations with an intimidating board sitting in front of them.

Patricia Cloherty, one of the board members and a venture capitalist who was more than accustomed to spreadsheets and ratio analyses, finally just closed her book and said, “Look, can you tell me just one thing? Who's going to do what to whom with how much?” Now if I had my way, that question would be on bronze plaques in every foundation in America. It is, in fact, *the* question. It frames everything we do.

Now looking back at the previous statement again, can you tell me who is going to do what to whom for how much? Looking at this example, who “worked to improve the capacity of state health systems?” The “program” did. Who “assessed state's health policy needs?” “Funded projects” did. Whose “health policymaking and program management” was “supported”? “The systems” was. Who got better data out of this? Quite possibly nobody, but “states” got an “improved health statistics infrastructure,” which I'm sure was good for something.

No *people*. Not one public official, not one consultant, not even a faceless committee. Nobody did anything to anybody with any amount of money, judging from this statement. Everything was a matter of abstractions acting on other abstractions.

This is how foundations talk about themselves, and it is how they talk about their goals, their programs, their grantees, and the things that are very important to them, and that are, in fact, important to everybody else. It is endemic.

Why does this happen? In part, I think it gets back to my first topic, which is a fear of risk, a fear of controversy. It is harder for critics to be opposed to abstractions. But I think there is something more than that here. It is more than just risk aversion. It is partly that most foundations do not have to talk frankly about what they do. There are no stockholders. There is no Securities and Exchange

Commission. There is no Food and Drug Administration to keep your statements true and frank and clear, or to set standards for accuracy and clarity.

And although some of you, particularly conversion foundations, do have regulatory overseers that you have to worry about, it is in fact better in dealing with them to do what I'm sure what your lawyers have told you to do: Keep what you say vague. No one, by and large, forces foundations to speak precisely about whom they will induce to do what, to whom else, with how much money. In fact, their lawyers, their trustees, their public relations consultants, all sorts of people, will encourage them to do exactly the opposite.

But before we start blaming the lawyers, I think there is something far less obvious and more universal at work here. It is something I encountered in absolutely no scholarly writing or serious discourse. I simply discovered it by wandering around the foundation world. To some extent, it seems to me, foundations make themselves seem vague and untrusting because they are too nice to be candid.

In my experience, foundation program staff hate to say no, but they have to do it all the time. So any opportunity they get to avoid that, they will take. They hate to be against anything. They want to be positive. They want to be upbeat. They want to be forward-looking. It is what draws us into this line of work — myself as much as anyone.

Take a look at this language, which is pieced together from an actual rejection letter that I believe is still being sent to this day in some form or other. (By the way, foundations are the only institutions in the world to use the word “declination.” I still consider this a *rejection* letter. Sorry.)

“Our guidelines do not permit us to consider your proposal favorably at this time. . . . As you can understand, we must decline support for many activities, irrespective of their merits, because of budgetary restraints and priorities.”

Now imagine you're a grantee. (I'm willing to bet serious money that no one in that organization performed this exercise, so we are going to do it here first.) You are a grantee. You have just sent a proposal to this foundation. You proposed to do something and you wanted a certain amount of money with which to do it. And this is what you got back. The answer was no. But not because the foundation didn't want to do what you proposed doing. And not because they didn't think you'd have done an excellent job of it. Not even because they had something else they'd rather do instead.

To your amazement, the answer is they are not *able* to support you. They physically can't do it. Their guidelines — written apparently by an evil overlord they are powerless to depose — have tied their hands. Worse yet, this poor foundation is so cash-strapped that their budgetary restraints have made it impossible for them even to *consider your merits*.

These are not the words that inspire trust. Who would receive that letter and say, “Maybe I should have a candid conversation with this institution about the weaknesses in my program model?” This is dishonesty in the guise of diplomacy. It is not intentionally dishonest. Here too, I know the people. This is not a dishonest institution. They have allowed themselves to lapse into this kind of language for fear of saying things that are going to hurt the grantees — things like, “That was a lousy proposal.” Or worse, “We do not even work in that area, why are you writing to us?”

Those are the kinds of things that are hard to say, and the nicer you are, the less inclined you are going to be to say it. So some lawyer gives you some language about guidelines and permissibility, and you may very well fall into it.

If trustworthiness starts with candor, and candor is voluntary, then the sad truth is that too few foundations ever volunteer. Small wonder then that grantees and other interested parties do not look trustfully toward foundations that seem so cagey.

Compassionate Power

Now the lack of compulsion in a foundation's world, which I referred to a minute ago, brings me to my third and last topic. And that is power. A little personal story here.

I was once on the editorial board of *The Miami Herald*, where we used to interview candidates every election cycle and make editorial recommendations in the run-up to Election Day. And these interviews were very formal, organized affairs. Everybody got an exactly equal block of time. They took place in the editor's office, this huge, dimly lit, oak-paneled thing with the editor behind a massive mahogany desk and the rest of us in comfortable chairs and sofas around the room. And the candidate was sitting in the circle with us, but in a hard chair, and we fired questions at him.

Now I remember particularly one interview with a really tough veteran of the Florida legislature, a woman you wouldn't take on if you weren't ready for a bare-knuckles fight. She'd been there a long time. She knew the ropes. And she feared no one. Or so we believed.

We interviewed her. We were almost certainly going to recommend her for re-election. She had done an excellent job. She didn't always like us. We were not always crazy about her, but she was far better than the alternatives. It was, I suppose, a fairly tough interview. The sort of thing you would do with somebody you consider pretty leather-skinned.

But when we were done with her, it was the end of the day and I was walking across the newsroom to the cafeteria. And at the far end of the newsroom, by a window, I saw this woman standing there in tears. And I reflected for a minute that I guess we had been a little tougher on her than usual, but I didn't think we had been unfair at all, and she had been far tougher on us in the past.

But what *I* thought didn't matter. When I saw what we had done to this woman, I recognized how much we underestimated our power — and worse, how easy it is to exercise power, when you're not thinking about it, in a cruel and oppressive way. We were not bad people, at least I hope not. But we had done a bad thing.

Now to take this back to the foundation world, I think it is fair to say that very few program officers are routinely aware of how much terror steps into their office when a grantee arrives at the door. And my experience is that, compared to most foundations, my editor's office was as welcoming as a day care center. It can be a very intimidating experience to be in a foundation and to face a foundation program officer, no matter how generous and gentle that person may be.

The experience, in and of itself, is freighted with power. And there's not much you can do about that except to be continually conscious of all the little, subtle, subliminal, symbolic components with which power gets exaggerated, even when you're not paying attention to it. Habits of style and phrasing, little symbolic gestures that nobody has paid attention to for years. All these things matter.

Take this one little statement from a foundation report I received recently: "An introductory meeting on state level reform included three state legislators, two mayors, two state cabinet members, and several Foundation staff." Sounds like a successful meeting. Do you see anything wrong with this sentence?

Look at the “F.” These people could have been meeting with the Pope, the Aga Khan and the Queen of Denmark, and all their titles would have been lower case except for the majesty of the foundation itself. That was unintentional. I am sure the decision was made by some proofreader working under contract, working off a style sheet that had been developed years ago by somebody who doesn’t even work at the foundation anymore. Nobody thinks about this.

And to argue that it is, by itself, a significant component in any foundation's relationship with its grantees would be ridiculous. It's simply one of the thousands of little symbolic gestures and attitudes that creep into the foundation's world without anyone intending or even noticing it.

The Wizard of Oz is a fantasy. There is no Toto to pull anybody out from behind the curtain and induce a conversation between equals. The disembodied face of Oz just keeps blabbing on and on, unless it chooses to stop. That's not how *you* see it, and it's not, in fact, the reality of what you are trying to do. But it is often how grantees see it. And therefore, the choice and the responsibility fall disproportionately to you.

It Could Be Worse

After what I hope doesn't seem too severe a discussion about risk and honesty, trust and power, I want to end by putting all of this into some kind of perspective. Because however much we in the foundation business may wish we had said things better, or made ourselves clearer, or improved our best behavior, no matter how bad we may get on our very worst day, we will never be quite as bad as the people who make the rules under which we live.

So I want to close with a little piece of information I received from a foundation official recently. A masterpiece, compared to which the worst of foundation gibberish flows off the tongue like the sonnets of Milton.

“The Internal Revenue Service has ruled privately that the partial termination and distribution to the remainderment of a charitable remainder unitrust by a surviving spouse entitles her to the income and gift tax deductions for a transfer to a charity and will not disqualify the trust.”

I don't know if that gives you quite the thrill it does me, but somebody *wrote* that. I mean, to have been present when DNA was discovered would have been a thrill, but I get the same kind of jolt from this. This text introduces me to exotic terms like “remainderment” and “unitrust” and the mind-bending notion of “partial termination,” which is I guess what the CIA ended up doing to Fidel Castro.

But my favorite thing about this sentence is the word “privately.” Mind you, this is what they say in *private*. Just imagine what their *public* pronouncements must sound like. That to me, is a perfect illustration of the impenetrable and arrogant use of power in language by people who have no intention of intimidating, but are actually communicating privately something that they hope will be useful to you.

No matter how bad we are, we will never rise to this standard. And I suppose that is one of the good things we can say about the work we do.

Responses to Questions

Program Officers: Responsibilities and Interventions

Intervention by itself is such a great word. In my view, the best thing is eternal vigilance. And there is no one form that it takes. But certainly, one form of eternal vigilance might be fire the proofreader and hire somebody from a grantee organization to tell you what the look and feel and sound of your message is. It

would be, to me, an enormous relief if a foundation that I was working for paid more attention to the humanity of what I'm helping them to say than to the number of commas I use.

But I will tell you that the amount of time and money and energy expended on those commas is triple what anybody ever asks me about how this will make the grantees feel. Or what this makes us sound like? Does this convey the kind of people we are? That sort of attention, believe me, is worth far more than making sure you have capitalized foundation or did not capitalize Queen of Denmark.

Another thing that can be done, and it is partly a board issue, I think, is periodically for somebody to stop the whole show and simply ask, in this program, in this initiative, in whatever it is we are doing this week, what are we saying about ourselves as an institution and as people, as individuals? What are we telling the world, and what are we asking the world to tell us as human beings? Have we shut down the smoke machine for the face of Oz? And that really does have to come from the top, in my experience. It is just one approach.

The Program Officer's Responsibilities

As a program officer you are answering to all sorts of people inside the institution and trying to communicate to people outside the institution. You are in a vise and there is not a whole lot of opportunity for you to do anything about that.

There is another explanation for why rejection letters and the act of saying no is done so vaguely and in such an unhelpful manner. One reason is: You hate to discourage people. And so you try to leave the door wide open, even while you are kicking people out of it. It is hard to serve both those masters.

You gain much more from the specificity and the honesty than you lose from seeming to close the door too much. I know very few program officers who are so passive that they rely on the grantees independently to come up with ideas to throw in over the transom. Almost any effective program officer is out there beating the bushes for ideas and opportunities all the time. And that is the vehicle for communicating the message that if your idea is really great, the door is open.

Conversely, suggesting to everybody else that the only reason we are not supporting you is because some guidelines were handed down by the Pope, is not only dishonest, it discourages the kind of honesty that you want from people when they do come in the door.

Then there is the need to toe dance around advocacy, an issue to which I am sympathetic, because I think it is one of the sillier rules in the nonprofit world. The ban on lobbying does put program officers in the bind of constantly having to come up with other descriptions for what strikes me as a perfectly honorable and even necessary philanthropic activity, which is: When you have found something that worked, you want to tell people to try it.

And that lands you in trouble not just with some overly fastidious lawyers, but with those people who wrote those regulations in the first place, who had every intention of stopping you from saying the things you need to say.

But the lawyers report to the trustees. I would love to be able to line up all the trustees who have said to me, "I am really grateful for your essays about jargon. We get too much of this stuff. It drives us crazy. We can't make sense of it." I would like to line them up on one side of the room, and on the other side of the room all the people who say "We write this way because the trustees require it." My hunch is that, standing in between those two camps, are advisors of various kinds, not just lawyers, who are telling the

trustees they need to require this stuff, and telling the program officers and other program staff that they need to write this way.

It seems to me the only people who can break through that barrier are the people with the power. That is the board, the executive director, or the president, and not very many other people. My answer to those trustees who say to me, “I’m glad you’re fighting this fight for us” is that I have absolutely no power, and nothing I have ever written is going to make a damn bit of difference in your world. Only you can do that. Unfortunately, I haven’t noticed much difference being made.

You have, by virtue of your ability to give away money, you have power and a responsibility to set an agenda — to decide what target you are going to attack with what weapons and with what means of delivery. (I apologize for the military metaphors, I guess it’s in the air these days.) Grantees are never going to take it with pure equanimity when they are told that you’re going to do with this money what you have set out to do, and they are not forced to comply. But if they want the money, they need to pursue the program.

An honest exercise of power, I think, is not only an effective strategy for foundations, it is an obligation. Pretending that you do not have the power, that the grantees really thought of all of this stuff and the foundation is merely enabling them, is very nice but I think it is similar to the tactic of telling them that you are not really rejecting them, that they simply are not going to get the money.

An honest acknowledgment that you have a strategy, you have picked a goal, you believe in that goal, you are only one person or one institution, there are other people who may disagree with you, but at this point you’re pursuing that goal because that is your responsibility — I think the only thing you can do honorably is to be honest about that. And everybody knows you have power. There is no point denying it. There is a point to using it honestly and candidly.

The Terrence Keenan Leadership Award in Health Philanthropy

*Awarded to Tom David, The California Wellness Foundation
Presented by Terri Langston, Public Welfare Foundation*

Introduction by Terri Langston

We come here today to present an award, and we do so in hard times. We all had a terrible shock last fall. But in the year preceding last fall, New Yorkers lost tens of thousands of jobs. Currently 3.5 million people are uninsured in the state. There are about 30,000 homeless people in New York. Many are children. Many are physically or mentally ill. We had a shock in Washington too, but we should be shocked every day that Washington manifests some of the worst disparities in health in the nation.

Let's leap across the country to California, where 20 percent of children under 18 years of age live in poverty and 19 percent are without insurance. We can find similar statistics in every community between New York and California. Everyday realities force us to look at the enemies within, the ones even harder to identify and to subdue than any foreign enemy: public disinvestments in those who need help, an ever growing gap between rich and poor, and a blatant insistence on valuing some lives more than others.

We present the Terrance Keenan Leadership Award in Health Philanthropy today. But as we do so, we must ask ourselves, "Are we merely an elite group of people with excellent jobs coming together to feature one of our own in order to congratulate ourselves?" It is not the time to do that. Rather, it is the necessity to focus on everyday realities that make the choice of the award winner particularly meaningful this year.

Now what would you have done about a decade ago if you had just been made president of The California Wellness Foundation? You were facing California's chilling health statistics and multiple health problems, facing state legislators who had larger-than-life expectations that the foundation would solve the problems of health access, facing a board that knew that what the foundation continued to do programmatically had to be excellent. Gary Yates was in that position.

What would you do? You would call Tom David. Just after he was appointed president, Gary said, "I called my wife and then I called Tom David. He was the first hire and the best hire to date." Other colleagues in California would have given Gary the same advice. Jan Eldred of the California HealthCare Foundation wrote, "Tom has always championed the underdog, been the first funder to support a new endeavor, been thoughtful and responsive in his grantmaking, and been a willing and flexible collaborator with other funders."

Over the past few years, I have been convinced of the character-building power of sports. Tom David played baseball as a boy when it really counts, and with regard to character-building, perhaps the only time it counts. One of the best things that has ever come out of baseball are the writings of A. Bartlett Giamatti. A scholar with a Ph.D. from Yale University, he was professor of Italian and comparative literature at Yale and Princeton. He rose above that to become the president of Yale, and he rose above that to become the commissioner of baseball. His essays on baseball are collected in a wonderful little book called *A Great and Glorious Game*.

In 1985, Giamatti addressed the Massachusetts Historical Society in a speech entitled, "Baseball and the American Character." He shows us the game as a 19th-century invention in the midst of America's most important redefinition up to that time. Because of the Civil War, he wrote, America would be compelled to

compose or recompose herself in the aftermath of division and upheaval: "Now there was no escaping the gap between America's promises and her execution of them."

Giamatti was well aware of the moral consequences of everything that we do in society; that there are no exemptions from our actions. Writing about the Californian and baseball player Tom Seaver, who lived up to Giamatti's exacting moral standards, he wrote, "Most Americans do not distinguish among Californians at all, and if they do, it is certainly not with the passionate self-absorption of the natives. Yet we should, for there are real differences among them; differences far more interesting than those implied by the contrast most favored by Californians themselves, the one between the self-conscious sophisticates of San Francisco and the self-conscious zanies of Los Angeles. There are, for instance, all those Californians, north and south, who are not self-conscious at all."

Even though Tom David has hovered at both ends of California, he has shown an ease and a lack of self-consciousness that has led him to be a leader in the health concerns of the entire state with notable skills. One deceptively simple skill is listening. Listening to grantees and the public not only catches issues before they become current, it also comprehends the true needs of people. Proof of Tom's listening was apparent in his tenure at the James Irvine Foundation. These were the early years of managed care. Tom initiated a grants program to assist rural hospitals with strategic planning. Later he provided grants for the planning and development of regional networks in anticipation of managed care.

Tom has always been aware of the need for access to care among traditionally underserved populations. Irvine was among the first foundations to make grants to community clinics and family planning agencies, and to develop significant women's health initiatives. Irvine also turned to AIDS and HIV infection, becoming one of the largest private funders of HIV-related work in California. For a number of years Tom played a critical leadership role in the Northern California Grantmakers AIDS Partnership, before the National AIDS Partnership came into existence. The Northern California Partnership became a model for regional AIDS partnerships across the country.

Even before evaluation became a frequent word among funders, Tom headed up the effort to listen through the evaluation of a cluster of grants that had been made to strengthen the management of AIDS agencies, and to promote cooperation throughout California. This was Irvine's first evaluation of a cluster of its grants, a practice that has been imitated many times since. Bart Giamatti points out that, "baseball fulfills the promise America made itself to cherish the individual while recognizing the overarching claims of the group." What a difficult and as yet unfulfilled promise in our country.

At The California Wellness Foundation, Tom David and Ruth Holton had experienced a long history of noncollaboration among individuals in health policy and advocacy organizations that had diluted their effect on the overarching concerns of all advocates and their beneficiaries for years. So Tom and

Ruth convened them in a room with a facilitator and no foundation staff. It takes a lot of wisdom and courage for foundation people to walk away, walk outside, and let people work it out. After heated discussion, the result was better collaboration and a request for continuing the retreat on an annual basis, which has occurred two more times.

The English writer George Elliott said, "To manage men one ought to have a keen mind in a velvet sheath." Now knowing Ms. Elliott, she probably meant male men with that. But she would applaud that we have made some progress in gender equality and she would let us use the statement generically. "A keen mind in a velvet sheath." That is what is needed to lead a foundation board through a policy discussion and consequent action.

At The California Wellness Foundation, Tom oversaw the establishment of priority areas. The nature of the areas themselves showed foresight: diversity in the health professionals, environmental health, healthy aging, mental health, teenage pregnancy prevention, women's health, and violence prevention. Tom touched not only the nature of the issues but also the duration of the efforts. An unparalleled example of a foundation taking the long view is The California Wellness Foundation's initiative on violence prevention that began as a 10-year commitment.

And core operating support! How many of us rejoiced when we saw the 1999 annual report of The California Wellness Foundation delineating the need and reasons for core operating support, which has been so prescient and timely? I have been so impressed with the local foundations that have talked so intelligently and knowledgeably about their experiences with core support, and what it means in capacity building. They add so much to our organization with their contributions.

Tom had led the board of the foundation through a planning process to examine the needs of the nonprofit sector, as devolution took its hold. This was a structurally crucial step that clarified grantmaking as an activity that needs to look at the organizational aspects of the nonprofit sector. Likewise, in one of his numerous publications, Tom stated that The California Wellness Foundation had "underestimated the needs of its grantees...for assistance with capacity building. Quite practically, the foundation realized that its own investments in grantees could be compromised if their organizational needs were not addressed." To help a foundation board condone things so seemingly unexciting as general operating support and capacity building truly requires a keen mind in a velvet sheath. So does recruiting and leading a program staff. Tom has hired and developed a collaborative team of 12 program officers, diverse not only in ethnicity but also in educational attainment and job experience.

On a personal note, Tom is kind. He is never arrogant, and not entitled. As we know, foundation people are in a power position. Whether we are dealing with our grantees, with our own staffs, or with the staff of Grantmakers In Health, we need to behave. We need to remember this power position. Tom is a great example in this regard.

Bart Giamatti wrote that baseball people have "the keenest eye for telling detail I have ever known." Tom's writings have exhibited a sensitivity to issues and to methods encountering grantmakers. In the issue of *Reflections* devoted to strategic grantmaking, Tom dealt with lingering controversies among funders and grantseekers, seeing the tensions not only from the funders' side but also from the side of community-based organizations that live every day in the gulf between policy and practice.

With regard to the ongoing tensions among grantmakers between proactive and reactive grantmaking, he asserted that either can be appropriate when in accord with mission, values, and operational philosophy. He further cools the air by preferring the term, “responsive,” to the term pejoratively used, “reactive.” A keen eye for telling detail indeed.

Throughout his career Tom has pioneered communication as an integral part of grantmaking. In the June 2001 issue of *The Chronicle of Philanthropy*, he published an article entitled, “Grantmakers' Focus on the New is Getting Old.” Tom wrote, “The obsession that foundations have with novelty can be a curse that they lay on grantseekers.” Taking advantage of the straightforward style of an op-ed piece, Tom said what desperately needed to be said: “support, strengthen, and sustain” are equally important, as important as “innovate, increase, and improve.” The insistence on innovation is a charade that wastes everyone's time. And choices in funding should not be matters of ego gratification or intellectual stimulation of program staff. Again, choices in funding should not be matters of ego gratification or intellectual stimulation of program staff.

Tom has always practiced truth telling. We in health philanthropy have before us every day a serious task in trying to build health equity in a large, complex, and diverse country. Equity remains a dream that many no longer believe in. In the jobs of philanthropy, it is too easy to delude one's self, to construct fantasies about the efficacy of one's work, to avoid critical thinking, to require too little of one's self and of others. Those who do not fall into these traps are our leaders.

Bart Giamatti wrote that “baseball best mirrors the condition of freedom for Americans that Americans ever guard and aspire to. Our national plot is to be free enough to consent to an order that will enhance and compound — as it constrains — our freedom. That is our grounding, our national story, the tale America tells the world.”

We work in one of the freest occupations available to people in this country. We must remember, as Giamatti writes, “The purpose of freedom is to show how to be free, and to be complete and connected, unimpeded and integrated all at once.”

There is still no escaping the gap between America's promises and her fulfilling them. No, we do not come here today to be self-congratulatory, but rather to let the work of one of the best of our colleagues remind us of our task to narrow the gap between America's promises and her fulfillment of them. That is what this award is about. It is what Terry Keenan is about, and it is what Tom David is about.

My colleagues, it is on your behalf that I present the 2002 Terrance Keenan Award for Leadership in Health Philanthropy to Tom David.

Acceptance Speech by Tom David

It is a distinct honor to receive an award named for Terry Keenan. Native Americans refer to elders who are the transmitters of knowledge to succeeding generations as wisdom keepers. Terry is unquestionably one of the wisdom keepers of our field. I had the opportunity to spend some time with him almost ten years ago and that meeting has had a lasting influence on the way I do my work.

I was one of many pilgrims who have knocked on his door over the years, and he not only made the time to meet with me, but he received me as a colleague, even though I was a relative novice. He exemplifies not only a thoughtful big picture approach to our work, but he is also a wonderful role model who sees philanthropy as a vocation, a true calling. His insightful writing sets a standard for all of us and his graciousness is legendary. If others believe I am following in his footsteps in some small way, that is a compliment of the most profound sort.

Since this work is not done in isolation, I'd like to begin by recognizing my colleagues at The California Wellness Foundation with whom I have the good fortune of working every day. They are an amazing group of people. I also see this recognition as a coming of age of sorts for health philanthropy on the West Coast.

Twelve years ago, those of us doing health grantmaking in California were part of a small village, and could gather around a single table for lunch. Some of those wonderful colleagues are here today and deserve special notice because this is a journey we have taken together: Ruth Brousseau (who now works with me at The California Wellness Foundation), Ruth Lyn Riedel (Alliance Healthcare Foundation), and Dorothy Meehan (Sierra Health Foundation). Others who aren't here today include Jan Eldred (California HealthCare Foundation), Mario Gutierrez (The California Endowment), Judy Spiegel (California Community Foundation), and Carol Larson (Packard Foundation). All are still at it today.

I've also been blessed with great bosses, who have been both teachers and mentors: Luz Vega Marquis at the James Irvine Foundation (who taught me how to do grantmaking); Dennis Collins, also at Irvine, (who gave me the space to learn how to develop a grantmaking program); Jess Erickson at the S.H. Cowell Foundation (who taught me much about boards and foundation management); and, of course, Gary Yates at The California Wellness Foundation. He is an inspirational leader who brings out the best in all of us. And, of course, I wouldn't be able to do this work without the love and support of my family: my parents, Fred and Loretta David, my wife Jane, and my son Owen. To all of them, I owe a tremendous debt of thanks.

But I owe a special debt to the many nonprofit leaders I have engaged with along the way, whether they were grantees or not. They are the most important reason I do this work and they are a continuing source of inspiration.

In the time remaining, I want to share a few thoughts about the work of grantmaking in health. After 14 ½ years at this work, I still consider myself to be a student. I have found it to be endlessly fascinating and challenging and fraught with paradox.

One example: If you take the challenge of due diligence seriously, it's hard to make the right decision. But it's also difficult to make a really bad decision; after all, most organizations that come to us for funding are worthy of some kind of support.

Moreover, I've found that the longer you engage in this work, the more there is to know. But that may simply be an admission of eroding cognitive capacity.

A master of paradox in my book was Mies van der Rohe, one of the giants of modern architecture. One of his masterpieces, the Seagram Building, is just down the street from here. As a student of

architecture, he was one of my heroes and I once had a t-shirt that featured his impressive Teutonic profile and his famous dictum “less is more.”

I'd like to pose at least four ways in which I think that paradoxical statement applies to our work:

The first is money. After all, that's where most philanthropic conversations begin and end. When I first started doing this work, I was startled to be asked the question, “How big are you?” Fortunately, when I didn't respond quickly, the questioner usually continued by saying something like, “we're about \$150 million.” Oh, they're talking about asset size!

And I think it's fair to say that the assumption is typically “bigger is better,” as with most things in America. But is it? From what I've seen, the more money you have to give away the more pressure there is to do things that can disrupt the ecosystem, if not violate common sense. For example, there's the temptation to give a small organization too much money too fast to help them get to scale or just because you can.

But in my experience, many of the best grants I've made were relatively small but proportionately appropriate. To riff on Margaret Mead's oft-quoted remark about the power of a small group of committed individuals, I'd say: never underestimate the power of a small amount of money in the hands of the right person at the right time.

I also think that when big bucks aren't on the table, there's the potential for a more honest transaction, more realistic about what can be done with the money versus mutual fantasies about the magnitude and pace of change that can be wrought with grant dollars.

Second is scale. In this work, an organization whose mission is national, regional or at least statewide is frequently seen as having the potential for more impact than one that is focused on a single locality. And it's frequently seen in that sort of descending order of significance. But I question that assumption. Understanding context is essential in this work. The more removed one is from the local context, the greater the tendency to think one can simply impose a common template, whether it be theoretical or organizational, on multiple locations, no matter how different they might be from one another in other respects. But the best theory is grounded theory, tested in face-to-face interaction with those on the front lines. Impact is very difficult to achieve absent that kind of deep understanding of local reality, and that favors the local funder over the national or regional.

Third is complexity and this is closely related to a belief that grantmakers should exert maximum control in order to achieve the desired results. The more we intellectualize the task at hand, placing importance on our own value added and focusing on refining our multidimensional theories of change requiring multiple simultaneous grantmaking components, and fine-tuning budgets, there is a tendency to forget that people will implement these plans (or not) and the real-world environment in which they operate is constantly changing.

After years of experience with some very complicated grantmaking programs, I've come to the conclusion that synergy cannot be engineered. When it does emerge, it tends to flow from simple, open structures that leave maximal space for adaptation and change.

While being mindful of the complexities of the fields in which we operate, the paradoxical challenge for grantmakers is to approach our work with the freshness of perspective of the novice, what Buddhist practitioners call *shoshin* or “beginner's mind.”

In the words of Shunryu Suzuki, one of the first Zen teachers on the West Coast, “in the beginner's mind there are many possibilities; in the expert's mind there are few.”

A fourth, related topic is innovation. Most people who do grantmaking would justify their existence by saying that they are investing in innovative approaches to solving problems. But the more we insist on new ideas or demonstration projects as a precondition for funding, I believe we may be unwittingly limiting the creative potential and ultimately weakening the organizations we hope to help.

The most thoughtful nonprofit leaders I know are engaged in an unending struggle for sustainability of their efforts in an unstable, uncertain funding environment. Virtually every one of their organizations is undercapitalized. Unless they are fortunate enough to enjoy a base of individual donors, they have a very difficult time raising unrestricted dollars that are not earmarked for a specific project or program. All too often, funders dangle the carrot of dollars only for new ventures that can take them outside their core mission and perhaps ultimately to their detriment. But how many can afford to pass up on such an opportunity?

Yet I'd argue that dollars for core support are exactly the fuel for creativity. It's what permits staff to step back from their day-to-day pressures to reflect on their work, learn from their experience and that of their peers, and implement changes in their programs. By providing that kind of unrestricted funding, foundations might paradoxically be most likely to support the kind of innovation we so highly prize.

As a final metaphor for the paradox central to our work, I'd like to share a bit about the story of the Polynesian Voyaging Society. It was founded in Hawaii in 1976 by three individuals — an anthropologist, an artist, and a lover of the sea. Their aim was to show that the ancient Polynesians could have purposely settled the Polynesian Triangle in double-hulled voyaging canoes using wayfinding or noninstrument navigation.

Their first project was to construct a replica of an ancient voyaging canoe, the first to be built in Hawaii in over 600 years. That canoe, *Hokule'a*, was launched in 1975. The following year, guided by a master navigator from Micronesia (Mau Pilaug), *Hokule'a* left on her maiden voyage to Tahiti, arriving in Papeete 33 days later to a rapturous response from nearly half the island's population.

Subsequently, Mau's Hawaiian protégé, Nainoa Thompson has piloted voyages to islands throughout the Pacific totaling more than 16,000 miles, including most recently, a trip to Rapa Nui (Easter Island) of more than 1,400 miles against prevailing winds.

To the modern western mind, this story defines paradox. Navigating a dugout sailing canoe across the open ocean to arrive at a tiny island without instruments? How is that possible?

It is through the transmission of indigenous wisdom of the most profound sort. The Hawaiian star compass is the basic mental construct for navigation. The navigator memorizes 220 stars and their “houses,” i.e., where they come out of the ocean and go back into the ocean. It is also used to read the

flight path of birds and the direction of waves. During the day, the position of the sun, wind, and swell patterns provide additional information. But that only hints at the total concentration and refined consciousness required of the navigator. After twenty years of navigation experience on the open ocean, Nainoa Thompson still refers to himself as a “student navigator,” noting that, “the principles of wayfinding are simple; the practicalities are very complex.”

The story of Hokule'a's voyages has been shared with schoolchildren and others throughout the islands and the work of the Polynesian Voyaging Society has been an instrumental part of the rebirth of traditional Hawaiian culture and a multigenerational healing process, helping contemporary Hawaiians recover and reclaim the wisdom and values of their ancestors.

While much of our work may seem mundane in comparison to that kind of spiritual power, it is connected because the most profound paradox of all is hope. In the face of seemingly insurmountable odds, committed individuals and organizations are struggling to provide healing and hope every day in communities where they are desperately needed. If we choose to, we have the privilege to support them in their work in some small way. It's been my good fortune to do so for the past 14 ½ years and I look forward to more. Because although the principles of grantmaking are simple, the practicalities are very complex.

Speaker Profiles

Thomas G. David

Tom David was executive vice president for The California Wellness Foundation at the time of this speech. He has since stepped down to pursue other interests. Prior to coming to the foundation in October 1995, he was vice president for grant programs at the S.H. Cowell Foundation in San Francisco. From 1987 to 1994 he was senior program officer with the James Irvine Foundation in San Francisco, where he was responsible for grantmaking in health. His previous positions included coordinator of clinical research, Division of Adolescent Medicine, Childrens Hospital Los Angeles, and director of the UCLA Bush Program in Child and Family Policy. Dr. David recently completed a term as board chair of Northern California Grantmakers and as a member of the board of Women and Philanthropy. Among his community service activities, he has served on the advisory committees of The Pacific Institute for Women's Health and the Children and Youth Policy Project, University of California, Berkeley. Dr. David received his master's degree in architecture and urban planning from the University of California at Los Angeles and his doctoral degree in educational psychology from the University of Chicago. For the 1998 - 1999 academic year, he served as a senior fellow, UCLA School of Public Policy and Social Research.

Martha Katz

Martha Katz is deputy director for policy and legislation at the Centers for Disease Control and Prevention (CDC). Prior to this appointment in December 1998, Ms. Katz was senior program director of the CDC Foundation, a private nonprofit agency whose mission is to improve health by enhancing the impact of CDC, the nation's prevention agency. From 1986 to 1995, Ms. Katz served as associate director of policy planning and evaluation for CDC. In this role, she initiated CDC programs in women's health and prevention effectiveness and directed CDC's initial effort to integrate over 100 disease surveillance systems. Ms. Katz also guided the transfer of the National Center for Health Statistics to CDC. Ms. Katz is a member of the board of directors of the Prudential Center for Health Care Research Foundation. She also teaches at the Emory University Rollins School of Public Health. As a member of the American Public Health Association, she served on the Governing Council as a chair of the Action Board. Ms. Katz holds a bachelor's degree from the University of Texas at Austin and a master's degree in public administration from the Lyndon B. Johnson School of Public Affairs at the University of Texas at Austin.

Teresa Langston

Terri Langston has served as a program officer for the Public Welfare Foundation since 1987, and is responsible for the Health Initiative and the Disadvantaged Elderly Initiative. She also serves on the board of Grantmakers In Health. Prior to joining the foundation, she was a development associate at the College of the Arts and Sciences of Georgia State University and development officer for the Wesley Woods Geriatric Center in Atlanta. Before this, she served as grants administrator and clinic director for the department of internal medicine at Emory University School of Medicine at Grady Memorial Hospital. Following completion of her master's degree in German from Ohio State University, Dr. Langston served as an English instructor and translator in Germany for the medical faculty at the University of Bonn Medical School. She received her doctorate in comparative literature from Emory University Graduate Institute of the Liberal Arts.

Lauren LeRoy

Lauren LeRoy is president and CEO of Grantmakers In Health (GIH). Before joining GIH,

Dr. LeRoy was executive director of the Medicare Payment Advisory Commission (MedPAC), a nonpartisan congressional advisory body. Prior to MedPAC, she served as executive director of the Physician Payment Review Commission (PPRC). She came to PPRC in 1986 from The Commonwealth Fund Commission on Elderly People Living Alone, where she served as associate director. Dr. LeRoy spent more than a decade at the Institute for Health Policy Studies, University of California, San Francisco, where she was assistant director and directed the Institute's Washington office. She began her career as an analyst working on health issues in the U.S. Department of Health, Education, and Welfare. Dr. LeRoy's research interests and published works have focused on Medicare reform, the health workforce, health care for the elderly, reproductive health, and health philanthropy. She is a member of the National Academy of Social Insurance and a fellow of the Academy for Health Services Research and Health Policy. In 2000, she chaired the Institute of Medicine's Committee on Medicare Payment Methodology for Clinical Laboratory Services which produced the report, *Medicare Laboratory Payment Policy: Now and in the Future*. She received a doctorate in social policy planning from the University of California, Berkeley.

Ian Morrison

Ian Morrison is an internationally known futurist, specializing in long-term forecasting and planning with particular emphasis on health care and societal change. He combines futures research, survey research, and policy analysis to help public and private organizations plan their longer-term future. Previously he served as president and senior research fellow at the Institute for the Future (ITF). Before joining ITF in 1985, Dr. Morrison spent seven years in British Columbia, Canada, in a variety of research, teaching, and consulting positions. He has coauthored several books and chapters, including *Future Tense: The Business Realities of the Next Ten Years*, *Reforming the System: Containing Health Care Costs in an Era of Universal Coverage*, *System in Crisis: The Case for Health Care Reform*, *Directing the Clinical Laboratory*, and *Looking Ahead at American Health Care*. He also has coauthored numerous journal articles for publications such as *Encyclopaedia Britannica*, *Across the Board*, *Health Management Quarterly*, *The British Medical Journal*, *New England Journal of Medicine*, *Health Affairs*, *Journal of the American Medical Association*, *Business and Health*, and the *Journal of Medical Education*. He received his doctoral degree in urban studies from the University of British Columbia. He also holds a master's degree in geography from the University of Edinburgh, Scotland, and a B.Phil. in urban planning from the University of Newcastle-upon-Tyne, England. Dr. Morrison is a member of the corporate advisory boards of Bristol-Myers Squibb and Interim HealthCare. He is also a member of the board of directors of Interim Services, a leading temporary services company.

Tony Proscio

Tony Proscio is a freelance writer and a consultant to foundations and nonprofit organizations. His clients include The Rockefeller Foundation, The Ford Foundation, The Pew Charitable Trusts, the Edna McConnell Clark Foundation, the Corporation for Supportive Housing, and the Local Initiatives Support Corporation. He is the author of *In Other Words: A Plea for Plain Speaking in Foundations*, and *Bad Words For Good*, both essays published by the Edna McConnell Clark Foundation. He is also coauthor, with Paul S. Grogan, of the book *Comeback Cities: A Blueprint for Urban Neighborhood Revival*, which Ron Brownstein of *The Los Angeles Times* described as "the most important book about cities in a generation." From 1995 to 1997, as New York City's deputy commissioner of homeless services, Mr. Proscio had chief operating responsibility for New York's 40 emergency shelters for homeless adults. In Miami, he established Homes for South Florida, a bank consortium for community-development lending, and later became associate editor of *The Miami Herald*, where he was lead editorial writer on economic issues and wrote a weekly opinion column.

Steven A. Schroeder

Steven Schroeder is the president and CEO of The Robert Wood Johnson Foundation. During his term of office, the foundation developed new programs in substance abuse and tobacco control, care at the end of

life, health insurance expansion for children, volunteer coalitions for homebound persons with disabilities, and generalism in medicine. Dr. Schroeder graduated with honors from Stanford University and Harvard Medical School. He trained in internal medicine at the Harvard Medical Service of the Boston City Hospital, in epidemiology as a member of the Epidemic Intelligence Service of the Communicable Diseases Center, and in public health at the Harvard Center for Community Health and Medical Care. He held faculty appointments at three academic health centers, and at both The George Washington University and the University of California, San Francisco (UCSF), he was founding medical director of a university-sponsored health maintenance organization. He has published extensively in the fields of clinical medicine, health care organization and financing, workforce, quality of care, health policy, prevention, and philanthropy. He has been a member of many professional organizations, and chairs the International Advisory Committee of the Faculty of Medicine at Ben-Gurion University in Israel. He has served on a number of boards, including the editorial board of the *New England Journal of Medicine*, the board of directors of the American Legacy Foundation and Independent Sector, and the board of overseers of Harvard College. He has received four honorary doctorates.

Bruce C. Vladeck

Bruce Vladeck is the director of the Institute for Medicare Practice. Dr. Vladeck is also senior vice president for policy of Mount Sinai NYU Health as well as professor of health policy and geriatrics at the Mt. Sinai School of Medicine and serves as a director of a number of nonprofit and for-profit organizations. From 1993 through 1997, Dr. Vladeck was administrator of the Health Care Financing Administration of the U.S. Department of Health and Human Services, where he directed the Medicare and Medicaid programs, and played a central role in the formulation and enactment of the Medicare, Medicaid, and child health provisions of the Balanced Budget Act of 1997. Before joining the federal government, Dr. Vladeck served 10 years as president of the United Hospital Fund of New York, and has held positions on the faculty of Columbia University, at The Robert Wood Johnson Foundation, and as assistant commissioner for health planning and resources development of the New Jersey State Department of Health. A nationally recognized expert on health care policy, health care financing, and long-term care, Dr. Vladeck has received many honors and awards and has published widely. He received his bachelor's degree, magna cum laude, from Harvard College, and his master's and doctoral degrees in political science from the University of Michigan.

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