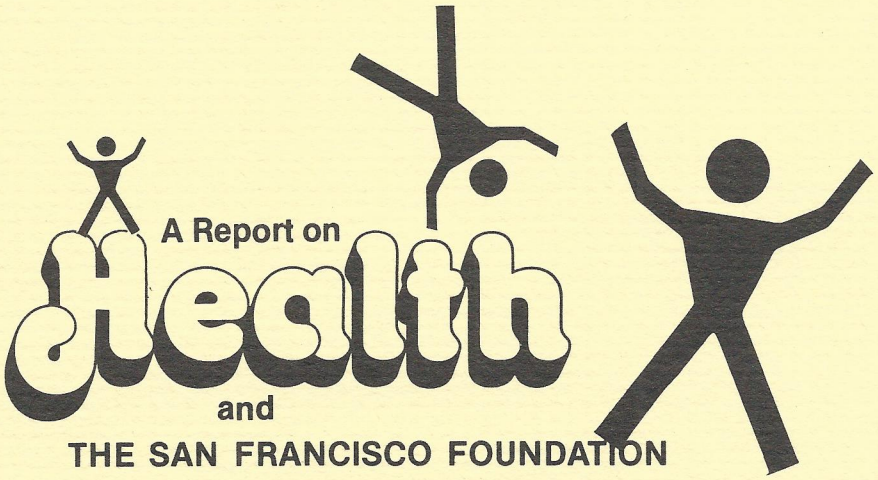

prepared by
Dana Ullman

and The San Francisco Foundation

prepared by Dana Ullman

The San Francisco Foundation - July 1979

Foreword

This report is part of a continuing series of studies sponsored by The San Francisco Foundation to help define critical issues in contemporary society in order to assist in arriving at responsible philanthropic decisions.

Throughout its more than thirty years of making grants to various health projects and programs, the Foundation has sought to stimulate an improved capacity for diagnosing and treating illness; grants have also been awarded to promote effective rehabilitation procedures associated with mental and physical impairment; and Projects aimed at health education, as well as better planning and managing of resources have attracted the interest and support of the Foundation from time to time. As this report demonstrates, however, although The San Francisco Foundation's involvement has been useful, and sometimes significant, it has not always been coherent or focused.

Dana Ullman's study causes us to examine many of the underlying assumptions that have guided our decisions over the years, and, perhaps, to recast our objectives relative to the health of the people in this region. The report asks that we examine the factors which predispose toward major illness, and urges us to help expand knowledge regarding effective intervention.

We are also prompted by the data to review how, and with what expectation, Foundation support has been applied in the past. We have seen what now appears to have been an inordinate investment in activities concerned with managing acute and chronic illness. Far less has been expended in dealing with causative factors, or promoting conditions of well-being. We have shown, in fact, an illness-orientation almost to the exclusion of concern for good health per se.

Because good health is among those social factors where public interest has been poorly defined, the result has almost inevitably been rather poor public policy. Indeed in contrast, say, to education, we have not defined what the public's health concern really is; therefore it is difficult to state what responsibility *ought to be. In education we have determined that for society to advance we must require at least minimal formal education for all. But such direct and significant reasoning is all but absent in relation to a formal social concept and commitment to health. The study argues, in fact, that society's investment in the treatment of illness has had only minimal effect on morbidity and mortality as indices of health.*

One of the many suggestions of this report is that greater emphasis be placed on individual knowledge, individual behavior, and ultimately individual responsibility. Helping the individual to assume and influence his or her personal health status needs to have a higher priority in our hierarchy of values says Ullman. In fact, he proposes the individual as society's single most neglected health care resource, the one with the greatest benefit potential.

Clearly, a rediscovery of the capacity of the individual does not imply an abandonment of existing essential resources and proven medical activities concerned with illness. This is precisely where public policy has its most important role to play. Individuals, when confronted with a health problem requiring organized skills and services, are at a loss to construct a response on their own. Most must turn to the community, at least for an appropriate resource, and very possibly for assurance of availability and access to health care facilities and services. There is no doubt that planning, organizing, managing and sustaining facilities and services that support the individual's efforts to maintain or regain robust health can and should be carried out in a more effective and efficient manner.

The Foundation therefore welcomes Dana Ullman's informed critique of our past activities in the health care field . . .

- *recognizes the validity of reexamining our assumptions*
- *agrees that we should seek a more positive prevention-orientation in our grant making*
- *strongly endorses the identification of the individual as the key and most promising factor in improved health status*
- *and commits itself to stimulating constructive change to assure more efficient service to all who may require it.*

Martin A. Paley

Summary

The purpose of this report is:

- to discuss major issues in health care today;
- to list and categorize health projects The San Francisco Foundation funded from 1976 to 1978;
- to critique the Foundation's present priorities in health;
- to consider various directions the Foundation can take in the health field; and
- to recommend specific health priorities for the Foundation.

Medicine is very effective for some specific physiological, psychological and emergency medical problems, however, there are numerous health problems that are not medical and where medical interventions are inappropriate and ineffective. Despite this seemingly obvious perspective, highly technological and very expensive medical solutions have continually been attempting to deal with an array of lifestyle and environmental problems that affect health.

The majority of the Foundation grants in the health field have been very successful projects. Despite this success, it is still important to ask what Foundation priorities in health offer the greatest possibility of assuring long-term improved health status for the Bay Area community. In this concern for long-range benefits, and with the recognition of the present crisis-oriented (short-range) care and the painfully high medical care costs, this report concludes that *the Foundation should fund projects that encourage individuals to assume greater responsibility for their own health and greater involvement in health care decision-making.* A contention of this report is that the citizenry are the most underutilized and lease expensive health care resource. It is this report's assumption that the potential for improving health status and increasing the quality of health care decision-making is great when individuals develop greater responsibility for their health and when they participate in decisions that affect them.

Our present approach in health care

Lewis Thomas, M.D., former Dean of Yale University Medical School and now at the Sloan-Kettering Institute, writing in The Saturday Review, discusses some of the accomplishments of medicine. After listing some of the best-known advancements, he then asserts, "There are other examples, and everyone will have his favorite candidate for the list, but the truth is that there are not nearly as many as the public has been led to believe."[1]

Most people credit medicine with the diminishing incidence of tuberculosis, scarlet fever, diptheria, whooping cough, and measles. Research, however, shows that these infectious diseases were all sharply declining in their incidence rate prior to the introduction of any medical therapy for them. Rene Dubos,[2] Thomas McKeown[3] and other reputable researchers have analyzed the history of these epidemics and have concluded that various public health measures dealing with food, sanitation, water, air and shelter played predominant roles in decreasing these diseases. Until now, the medical approach has been highly specialized, technological, and crisis-oriented. In order to realize the extent to which medical care today is characterized by these three factors, it is useful to elaborate on each.

Medicine is highly specialized. In 1970, the American Medical Association formally recognized 29 new specialties, bringing the total to 63 at that time. As of 1975, only 55% of all physicians in the United States dealt with primary care (general practitioners, internists, obstetricians, and pediatricians). If the present trends toward specialization continue, only 45% of licensed physicians will offer primary care in 1980.[4] This change means that there are fewer physicians practicing primary care where most people need them and more physicians practicing crisis-oriented and expensive secondary and tertiary care.

Dr. Bunker, Professor at Stanford Medical School, discovered there are twice as many surgeons in the United States in proportion to the population as in England and Wales, and that there is twice as much surgery performed in the United States as in England and Wales.[5] Other researchers have found similar patterns showing a higher number of surgeries associated with relatively large numbers of surgeons when comparing different communities within the U.S.[6]

Medicine is highly technological. Hospitals are arming themselves with all the most recent technological equipment, often to maintain and attract a highly specialized staff. It costs $100,000 per bed to equip intensive and cardiac care units in hospitals. The number of such units has increased from 2,643 in 1968 to 4,254 in 1976. Staffing this type of unit requires an average of 3.1 employees per patient as compared with 1.8 employees about 20 years ago; this further contributes to the price of medical care.[7]

There has not only been a large increase in the number of treatment technologies, but there has also been a substantial increase in diagnostic technologies. In 1971 there was a total of 2 billion laboratory tests done in the U.S. By 1974 this number rose to 3 billion a year. The exponential increase in lab tests then continued to rise to 4.5 billion in 1976.[8] It is uncertain if this increase actually raises medical care costs because certain lab tests are cheaper when ordered in a panel of numerous tests. Still, some experts express concern for the overuse of lab tests which tend to result in the objectification and dehumanization of patients.

Medicine is crisis-oriented. Our medical care system has been devoted primarily to crisis care offered by health professionals rather than health prevention. Of the $128 billion spent on health care in the United States in 1976, only 2-2.5% went for specifically identified preventive measures and only .5% for health education.[9] These figures indicate that the vast majority of health care funds are directed to a minority of ill people, while relatively few dollars are spent teaching people how to maintain their health. A clear example of the problems that this disparity creates can be understood by analyzing the health care system's effort in dealing with the nation's number one cause of death: heart disease.

Presently, heart disease is the primary cause of over 750,000 deaths a year in the U.S. One of every three deaths is attributable to this disease. The usual treatment for individuals with heart disease is medication to lower blood pressure and to control arrythmias, anginal pain and congestive heart failure. Some dietary advise, and often a couple words about the need to exercise and relax are sometimes added. Physicians, however, rarely recommend a program for people to pursue on an individualized basis.

When medication is not sufficient for reducing heart pain, coronary bypass surgery is frequently recommended. In 1977, approximately 70,000 bypass operations were performed in the United States at a cost of $8-12,000 per operation.[10] The high cost of this crisis care results in questionable benefits. Recent research by the Veterans Administration of 5,538 coronary patients discovered that coronary bypass operations did not improve the overall survival rate for surgical patients when compared with patients medically supervised without surgery.[11] While this is still a hotly debated issue, current evidence fails to fully justify the commitment to date.

The specialized, technological, and crisis-oriented approach of medicine to health problems fosters expensive health care. Two essential questions to ask at this point are: 1) what are the costs of health care in the Unites States today? and 2) what is the health status of Americans today? By discussing briefly these questions, a better understanding of the appropriateness and effectiveness of the present approach to health can be reached.

The present cost of medical care creates individual financial hardship and adds to the ailing economy. In 1950, health care cost accounted for 4.6% of the Gross National Product. In 1960, that figure rose to 5.2% and at present, it is approaching 9%. In order to understand these figures better, it is helpful to translate them into costs per person: in 1950 the annual per capita expenditure on health care was $87; in 1970 this figure rose to $147 per person; and in 1975 this figure increased substantially to $550 per person. Further, a 1976 HEW report states that health care costs will probably exceed $1,000 per person by 1980.[12]

Health care costs, however, are only the most externalized symptom of the present crisis in health care. In a report published in September, 1978, by the Kellogg Foundation on "The Cost and Productivity of Health Care in the United States," twelve reasons were given for the increase in expenditures for health care:[13]

(1) advances in medical technology
(2) increased demand for services
(3) rising age of population
(4) people expecting to receive the highest quality health care
(5) defensive medicine (the ordering of many laboratory tests to minimize risks of law suits)
(6) reimbursement system (provides little incentive for efficient hospital operations and little incentive for people to care for themselves)
(7) inefficiency/low productivity
(8) government relations
(9) inflation
(10) duplication of services
(11) numbers and training of health professionals
(12) reliance on acute care.

The rise in health care costs, thus, is the result of numerous factors. However, any effort that only seeks to lessen costs could have an adverse effect on the quantity and quality of health service. Therefore, it is important to avoid reducing health care costs if other fundamental changes are neglected.

Despite the great sums of money spent on health care, there is growing evidence to show that more Americans are being affected by chronic diseases such as heart disease, cancer, arthritis and diabetes. Recent research has also shown that chronic ailments are in fact increasing for people under 17 years of age.[14]

Another way of showing the existence of our ailing population is to look at the present consumption of drugs. Approximately 20,000 tons of aspirin are consumed each year, almost 225 tablets per person.[15] Dependence on prescribed tranquilizers has risen 290% since 1962.[16] One widely quoted study estimates that in less than a 36 hour period, between 50 to 80% of the adult population in the United States and the United Kingdom takes a prescribed or "medical" drug.[17]

While many people have referred to our present times as the atomic age, the space age, today may as well be considered the drug age.

In support of medicine, people frequently refer to its importance in prolonging the lifespan of people today. Epidemiological research now shows, however, that medical care has little influence on improving mortality rates in this country. Statistics show that an infant born in 1970, as compared to infants born in 1900, has a much improved chance of reaching 70 years of age. The statistics, however, also show that a 40 year old individual in 1900 has almost the same chance of reaching 70 years of age as the 40 year old individual today. Research has shown that the improvements that were crucial for helping infants live longer were sanitary and nutritional factors more than any improvements in medical interventions.[18, 19]

To now directly answer the two questions previously posed, it has been shown that health care costs are very high and presently show no signs of abating, and yet the health status of Americans has shown relatively little significant improvement despite the investments in medicine that have been made.

The many reasons that underlie health care cost and the growing numbers of people affected by chronic disease are creating a crisis that is demanding our society's attention. We have lost sight of the diverse determinants of health, and we need to look to medicine and outside of medicine to determine methods to deal with health problems.

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Health

Determinants of Health

In the past, it was assumed that more medical care meant better health status for the population. There are, however, few studies that show the number of physicians or the amount of medical technology has an appreciable effect on raising the health status of the community.

One of the most frequently used measures of health status is the infant mortality rate. Studies that have compared infant mortality rates among various states in this country have not reflected any significant correlation between the rate and the number of physicians per capita, even after income, schooling and other possible intervening variables are taken into account.[20] The United States ranks 14th in the world in having low infant mortality rate, which is poor considering that the U.S. is one of the wealthiest countries and has the most health care technology in the world. It is important to note that even the presence of free national health services does not guarantee low infant mortality rates, as the fairly high rate in the United Kingdom indicates.

A lack of correlation between the amount of medical care and a community's health status can be further understood when comparing Utah and Nevada.[21] These two states are comparable with respect to income, schooling, degree or urbanization, climate, and many other variables frequently thought to be the cause of variations in mortality. The two states also have a similar number of physicians and hospital beds in ratio to the population. Yet, the inhabitants of Utah are among the healthiest individuals in the U.S., while the residents of Nevada are among the unhealthiest.

The point in mentioning this example is that although there are no appreciable differences in the characteristics of the individuals in the two states which are usually theorized as causes of death and although there is a similar amount of medical care available in the two states, the differences in lifestyle provide insight into the health problems and possible health solutions. Utah is inhabited by large numbers of Mormons who tend not to use tobacco or alcohol and who tend to lead a generally stable life. Nevada residents, in comparison, have very high rates of cigarette and alcohol consumption and have a very high rate of marital and geographical instability. Higher morbidity (disease) and mortality (death) rates have been correlated with all of these behaviors. After many decades of research and medical care and after millions of dollars have been spent, it has been discovered that medical solutions tend to have little impact on these lifestyle problems.

Despite the growing recognition that lifestyle and environmental factors are strong determinants to health, medicine has directly and indirectly assumed responsibility for the great majority of health problems. Three examples of the inappropriate application of medical care are seen in treatment of cancer, in mental health care, and in childbirth. Although medicine definitely has a valuable role in each of these health concerns, it is questionable if the dependence on medical care along is appropriate or cost-effective. For example, although conservative estimates hold that 50 to 80% of cancers are environmentally related, tremendous amounts of money are still devoted to treating people medically and researching possible physio-biochemical causes of cancer, while little is done to help individuals or communities to deal with or control the stresses of the physical or social environment. An example of the overreliance of medical care in the mental health field is evidenced by the amount of tranquilizers prescribed, when a great number of mental disorders appear to be psycho-social rather than biochemical in nature. Finally, misuse of medical care occurs in childbirth as witnessed in recent substantial increases in electronic fetal monitoring and in Caesarian sections. Although these new and expensive procedures may be appropriate in selective cases, numerous studies are now questioning the efficacy and appropriateness of these frequently used medical procedures.[22] Our society's overreliance on medical care in childbirth is also evidenced in laws outlawing the practice of midwivery. Presently, many healthy pregnant women do not have the opportunity to choose a midwife-supervised hospital or home delivery. These pregnant women, thus, are given little choice but to have a more expensive specialist-supervised hospital birth.

Eliot Friedson, well-known medical sociologist and author of *The Profession of Medicine,* summarized the over-extended role of the physician:

> "The medical profession has first claim to . . . the label of illness and ANYTHING to which it may be attached, irrespective of its capacity to deal with it effectively."[23]

And how effective is medicine for dealing with all health problems? Richard E. Palmer, M.D. and 1977 President of the A.M.A, cited:

> "The best estimates are that the medical system . . . affects about 10% of the usual indices for measuring health. The remaining 90% are determined by factors over which doctors have little or no control."[24]

Warren Winkelstein, M.D., M.P.H., Dean of U.C. Berkeley's School of Public Health stated in a frequently quoted article:

> "I believe that in the United States the incidence and prevalence of all of the ten diseases and conditions responsible for the highest mortality and morbidity are unaffected by the most vigorous application of the disease or medical care system."[25]

Well, then, what are the determinants of health and what is the role of the physician? Marc Lalonde, former Minister of National Health and Welfare in Canada, describes a framework for answering this question. This working document, A NEW PERSPECTIVE ON THE HEALTH OF CANADIANS,[26] has received international acclaim. Lalonde developed a conceptual frame-

work called the Health Field Concept (see Figure 1). Within this framework, there are four determinants to health:

(1) HUMAN BIOLOGY (all aspects of health developed within the body based on the individual's organic make-up);

(2) ENVIRONMENT (all physical and social factors external to the individual over which one has little or no control);

(3) LIFESTYLE (the aggregation of decisions by individuals over which they do have control);

(4) HEALTH CARE ORGANIZATION (all people and other resources given to the provision of medical care).

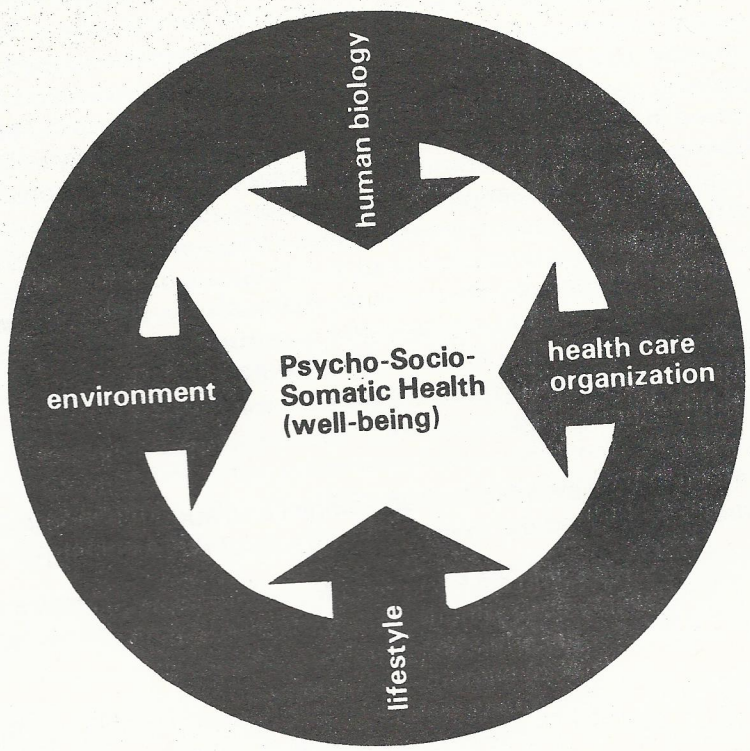


Figure 1: Determinants to Health

Lalonde states that one of the uses of the Health Field Concept is in determining the appropriate utilization of resources in effort to lessen specific health problems. He recognizes that health problems are not the result of a single influence but are the result of multiple factors. He also acknowledges that health problems do not always require medical care solutions. Lalonde cites, for example, that morbidity and mortality for automobile accidents are influenced by "Lifestyle, Environment, and Health Care Organization" factors which he estimates to have 75%, 20% and 5% influence respectively on the problem.

Lalonde does not define any one of the four determinants to health as having overriding importance for all health problems. He asserts that each health problem has multiple factors with relative degrees of effect upon health. Lalonde does try, however, to restore recognition of the important role of the physical and social environment in individual and community health and the important role of individuals' lifestyle.

Part II: Review and Classification of San Francisco Foundation Health Grants

The intent of this section of the report is to provide a summary and overview of the grants The San Francisco Foundation has approved in the health field. A list and short summary of each health grant between 1976 and 1978 is given. Each grant is classified according to two major groups: projects oriented towards the "Provision of Health Services" and towards the "Provision of Health Education". There is also a category for projects oriented toward the "Provision of Health Service and Health Education". Within each of the two major groups are four sub-groups each. A project fits into a categroy based on its primary orientation as determined by the purposes for which the Foundation provided funding.* As with any classification system, there are many projects that fit multiple categories. Although there is no clear-cut remedy for this, it is partially resolved by allowing a specific project to be listed in up to two different categories.

The definitions of the categories are as follows:

I. **PROVISION OF HEALTH SERVICES:** Projects primarily oriented toward treatment of individuals, or projects that research, plan or organize one or more agencies to offer treatment to the individual.

(1) MEDICAL CARE: Diagnosis and/or treatment of individuals by physician or allied health professional (MC)

(2) MENTAL HEALTH: Diagnosis and/or treatment of individual's mental health (MH)

*Determination of grant classification was made in consultation with L.A. White, Associate Director.

(3) PREVENTION: Medical screening to detect disease conditions or tendencies towards disease conditions (PREV)

(4) MISCELLANEOUS HEALTH SERVICES MISC-HS)

II. **PROVISIONS OF HEALTH EDUCATION:** Projects primarily towards education of individuals or groups of people on health concerns, or projects that research, plan, or organize one or more agencies to offer health education.

(5) HEALTH INFORMATION: Provision of information to individuals or groups of people with primary emphasis on raising person's knowledge of health mattrers (HI)

(6) HEALTH PROMOTION: Provision of educational programs to individuals or groups of people with primary emphasis on increasing person's health behavior or attitude (HP)

(7) ENVIRONMENTAL HEALTH EDUCATION: Projects that offer health education with primary emphasis on improving physical and/or social environments of people (EHE)

(8) MISCELLANEOUS HEALTH EDUCATION: (MISC-HE)

(The abbreviation after each definition will be used to describe the classification ascribed to each grant. The abbreviation "DD" refers to director's discretionary funding which are grants of $5,000 or less recommended by the Foundation's director.)

REVIEW OF THREE YEARS OF HEALTH GRANTS — January 1976 to December 1978

This review of the Foundation's health grants is not intended as an evaluation of the success or failure of these grants, but as an overview of what areas within the health field the Foundation has provided funds.

The following is a list of health grants (except grants made from highly restricted trusts and grants below $3,000).

A. PROVISION OF HEALTH SERVICES

ALAMEDA HEALTH CONSORTIUM, Alameda; Help with a central organization of eight community medical clinics serving a variety of racially and culturally distinct groups. $30,000 (5-76); $5,000 (3-77); $30,000 (6-77); $24,185 (9-78) — (HS-MISC)

AMERICAN CANCER SOCIETY, San Francisco; The Miller-Bunting Program for Cancer Patients provides attendant care and maintenance to cancer patients in San Francisco, with primary orientation to those who are medically indigent in the terminal stages of cancer. $150,000 (2-77); $100,000 ('78) — (MC)

BAY AREA BLACK NURSE'S ASSOCIATION, San Francisco; Counseling service for minority nursing students for an interim three-month period. $3,150 (10-76) (DD) — (MH)

BAY AREA HOSPITAL OUTPATIENT DEPARTMENT CHIEFS, San Francisco; A six-month study of problems of outpatient department billings for Medi-Cal reimbursement. $30,000 (9-77) — (HS-MISC)

CENTRAL CITY HOSPITALITY HOUSE, San Francisco; To provide interim funding for a free health clinic in the Tenderloin. $9,640 (9 months, 11-76); $5,118 (3 months, 9-77) — (MC)

C.H.A.N.G.E., Inc., Alameda; Support for a multi-faceted mental health clinic serving the psychological and social needs of low-income Black clients. $30,902 (5-76); $7,500 (6-77); $23,402 (9 months, 9-77) — (MH)

DELTA MEMORIAL HOSPITAL, Contra Costa; Support for a satellite clinic of a community hospital in a medically underserved rural community in Northeast Contra Costa County. $15,000 (5-76); $11,235 (9-77) — (MC)

EAST OAKLAND FAMILY HEALTH CENTER, Alameda; A project designed to aid in the documentation and analysis of mental health services provided by this clinic with the intent of learning more about psychiatric problems among low-income Black children. $71,318 (6-78) — (MC/MH)

HEALTH SERVICES RESEARCH FOUNDATION, Bay Area; Covers the salary for an area coordinator and other administrative costs to conduct a summer minority student work/study program. $3,500 (5076) (DD) — (HS-MISC)

HOSPICE OF MARIN, Marin; To provide home care services for terminally-ill patients with a primary orientation to the alleviation of pain and secondarily towards counseling services to the family during the period of bereavement. $25,000 (6 months, 4-77); $23,190 (11-78) — (MC/MH)

JOINT PEDIATRIC PLANNING, Santa Clara; Integration of major pediatric health care resources of Children's Health Council of the Mid-Peninsula, Children's Hospital at Stanford and the Department of Pediatrics of Stanford University Medical Center. $10,000 (3 months, 11-77) — (HS-MISC)

NATIONAL COMMUNITY FOUNDATIONS MENTAL HEALTH PROJECT, Bay Area; Establishment of a network of approximately ten community foundations focusing on the field of mental health. $7,500 (10-78) — (MH)

OAKLAND UNIFIED SCHOOL DISTRICT/SCOLIOSIS SCREENING PROJECT, Alameda; A screening program at the Oakland Schools aimed at identifying early cases of scoliosis among children ages 9 to 14. $9,027 (11-76) — (PREV)

OPERATION CONCERN, San Francisco; A mental health program within the Presbyterian Medical Center providing comprehensive services to gay clients and their families. $26,000 (12-78) — (MH)

PLANNED PARENTHOOD, Alameda-San Francisco; A grant to the Freedom of Choice Fund to provide subsidy for disadvantaged women denied state funding for early abortion. $50,000 (4 months, 2-78) — (MC)

PLANNED PARENTHOOD ASSOCIATION, San Mateo; A comparative family planning study on 5,000 patients to demonstrate the efficiency and effectiveness of a method and technique for screening and detection of medical conditions related to VD, cancer, etc. $20,000 (6-77); $4,435 (6-78) — (PREV)

ST. LUKE'S NEIGHBORHOOD CLINIC, San Francisco; To offset the Clinic's deficit and to assure continuance of out-patient services. $5,000 (6-78) — (MC)

ST. MARY'S HOSPITAL AND MEDICAL CENTER — VIETNAMESE PROJECT, San Francisco; To underwrite initial costs associated with an interpreter for Vietnamese refugee patients. $4,545 (12-76) (DD) — (HS-MISC)

SAN FRANCISCO REGIONAL TUMOR FOUNDATION, San Francisco; Planning for the establishment of Hospice of San Francisco in addition to a regional coordinating agency to meet the needs of the individual and family when the onset of death is near. $45,000 (6 months, 6-77) — (MH-HS-MISC)

SOUTHERN ALAMEDA COUNTY COMITE FOR RAZA MENTAL HEALTH (La Familia Counseling Center), Alameda; A new and innovative series of approaches to the diagnosis and treatment of emotional and psychological problems of Spanish-speaking children. $122,406 (6-78) — (MH)

STANFORD UNIVERSITY, Santa Clara; Viral research from patients with various types of malignant lymphoid tumors. $40,000, Gregory Fund, restricted to medical research (11-76) — (MC)

TELEGRAPH HILL MEDICAL CLINIC, San Francisco; Assistance for an initial period with the Clinic's health and medical care service. $5,000 (DD) — (MC)

URBAN INDIAN CHILD RESOURCE CENTER, Alameda; A mental health program for Indian children and families designed to provide direct services and in addition to develop professionally trained indigenous therapists. $125,198 (6-78) — (MH)

VOLUNTEER BUREAU/VOLUNTEER ACTION CENTER OF SAN MATEO COUNTY, San Mateo; A program placing individuals recovering from mental illness in volunteer positions in social service agencies. $11,450 (5-76) — (MH)

B. PROVISION OF HEALTH EDUCATION

BERKELEY DEPARTMENT OF PUBLIC HEALTH, Alameda; A study of the effects of the Berkeley Smoking Pollution Control Act of 1977, which prohibits all forms of smoking within all areas open to the public in business establishments providing goods and services. $4,294 (2-78) (DD) — (EHE)

CITIZENS FOR BETTER NURSING HOME CARE IN ALAMEDA COUNTY, Alameda; An ombudsman program in nursing homes in Alameda County to improve services to patients. $37,833 (6-77); $24,770 (9-78); $7,000 (9-78) — (EHE)

CONCERN FOR DYING, San Francisco; A conference on death, dying and decision-making, involving ethnics, religion, and public policy issues. ($3,000 (10-78) (DD) — (HP/EHE)

COALITION FOR THE MEDICAL RIGHTS OF WOMEN, San Francisco; A project that produces educational materials and influences policy in issues relating to the special health care needs of women. $25,000 (11-76); $13,540 (4-78) — (HI/HP)

NORTHERN CALIFORNIA BURN COUNCIL, INC., Bay Area; For the establishment of emotional support systems at six burn centers in the Bay Area. $30,000 (3 years, 2-78) — (HP/EHE)

SAN FRANCISCO SEX INFORMATION, San Francisco; Seminars on sex for adolescents. $8,000 (6-77) — (HI)

UNIVERSITY OF CALIFORNIA, San Francisco; A comprehensive women's health program at San Francisco General Hospital with special emphasis on patient education and the use of midwives in the field of reproductive medicine. $110,000 (1-76); $60,945 (4-77) — (HP/EHE)

C. PROVISIONS OF HEALTH SERVICES AND HEALTH EDUCATION

A.C.C.E.P.T, San Fransicso; An early-stage preventive counseling program and long-term after-care program for alcoholics who seek an alternative to traditional medical and residential services. $10,000 (11-76) — (MH/HP)

BAY AREA CONSUMERS HEALTH CARE, INC., Alameda; To assess and strengthen board and staff of an organization providing pre-paid health care. $5,000 (DD) (9-76) — (MC/HE-MISC)

COMMONWEAL, Marin; Help with the establishment of a multi-faceted therapy and research program dealing with nutritional and environmental toxins and their effect on learning and behavior disorders of children. $100,000 (over two years, 5-76) — (MC/EHE)

DIABASIS, San Francisco; A drug-free residential program for treatment and rehabilitation of young schizophrenics. $30,000 (6-77); $15,000 (9-78) — (MH/HP)

GARDEN HOSPITAL JERD SULLIVAN, San Francisco; To provide a social setting for recovering alcoholics. $15,000 (9-76); $10,000 (11-77) — (HS-MISC)

HEARING SOCIETY FOR THE BAY AREA, Bay Area; An alcoholism program for the deaf. $7,269 (9-77) (DD); $22,126 (9-77); $26,030 (6-78) — (MH/EHE)

MID-PENINSULA HEALTH SERVICES, INC., San Mateo; To provide support for a home-care program in conjunction with a new consumer-oriented cooperative health plan. $26,000 (6-76); $25,000 (10-77) — MC/HP)

MOUNT ZION HOSPITAL AND MEDICAL CENTER, San Francisco; To research and evaluate the Alternative Birth Center program. $38,139 (Two years, 11-76) — (MC/EHE)

NORTH OF MARKET SENIOR SERVICE CENTER, San Francisco; A preventive, health education program for the elderly living in ten hotels in the North of Market area of San Francisco. $18,525 (12-76) — (PREV/HP)

ON LOK SENIOR HEALTH SERVICES, San Francisco; Help for a comprehensive and nutritional program with the elderly in the Chinatown-North Beach area of San Francisco. To provide one year's salary for a Special Assistant for Program Education and Development. $17,720 (3-77); 5 month's salary $7,755 (2-78) — (PREV/EHE)

OVER 60 HEALTH CLINIC, Alameda; Support of a geriatric health services program. $18,750 (11-78) — (MC/EHE)

SAN FRANCISCO MEDICAL CENTER OUTPATIENT IMPROVEMENT PROGRAM, INC., San Francisco; To create the Patient Advocate Multicultural Program in efforts to fulfill patient advocacy and interpreting needs for non-English speaking people in San Fransicso. $4,422.62 (11-78) (DD) — (MC/HI)

SHANTI PROJECT, Alameda; A program providing volunteer counseling services to the terminally-ill and their families. $20,000 (9-76) — (MH/EHE)

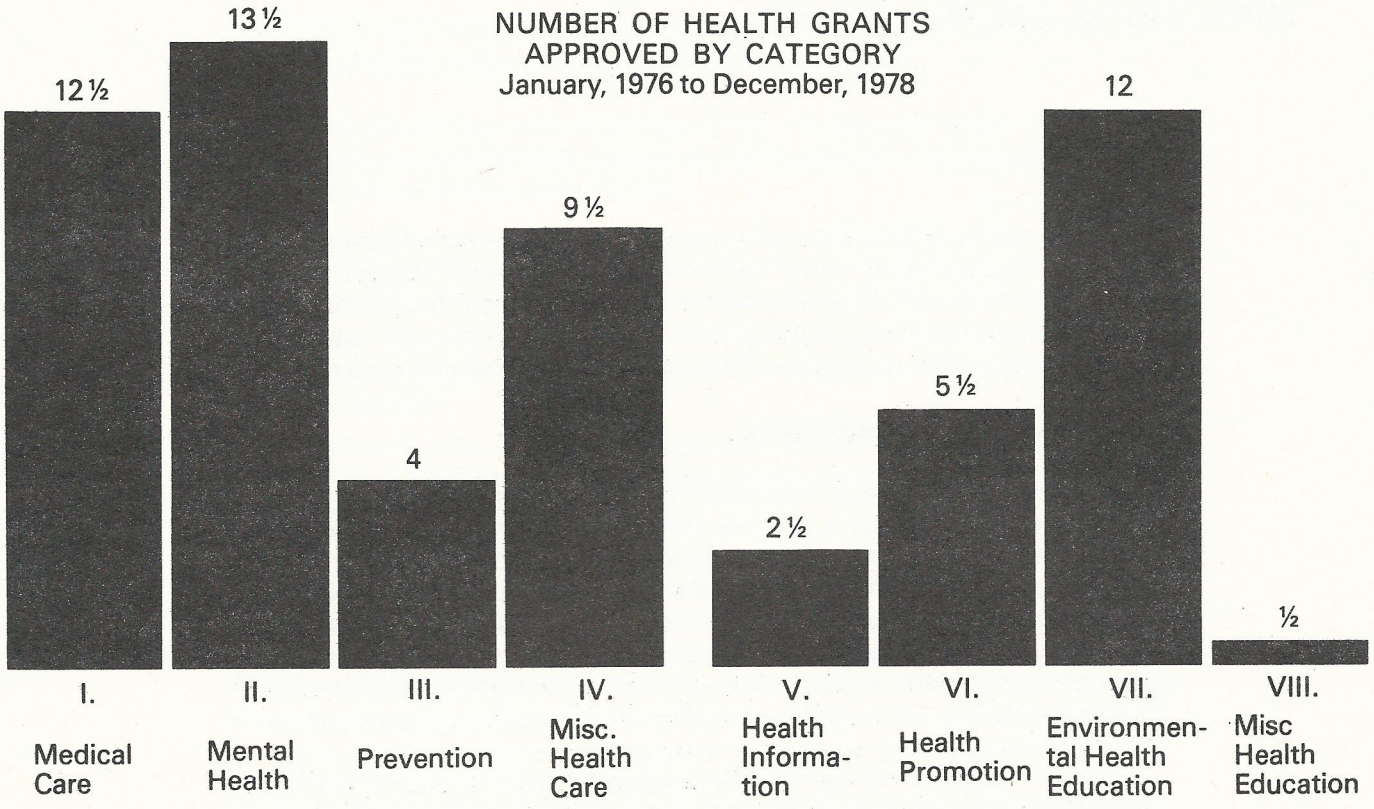
URBAN AND RURAL SYSTEMS ASSOCIATES, San Francisco; Technical assistance in support of the Foundation's projects to meet the emotional needs of minority children. $103,460 (1978) — (MH/EHE)

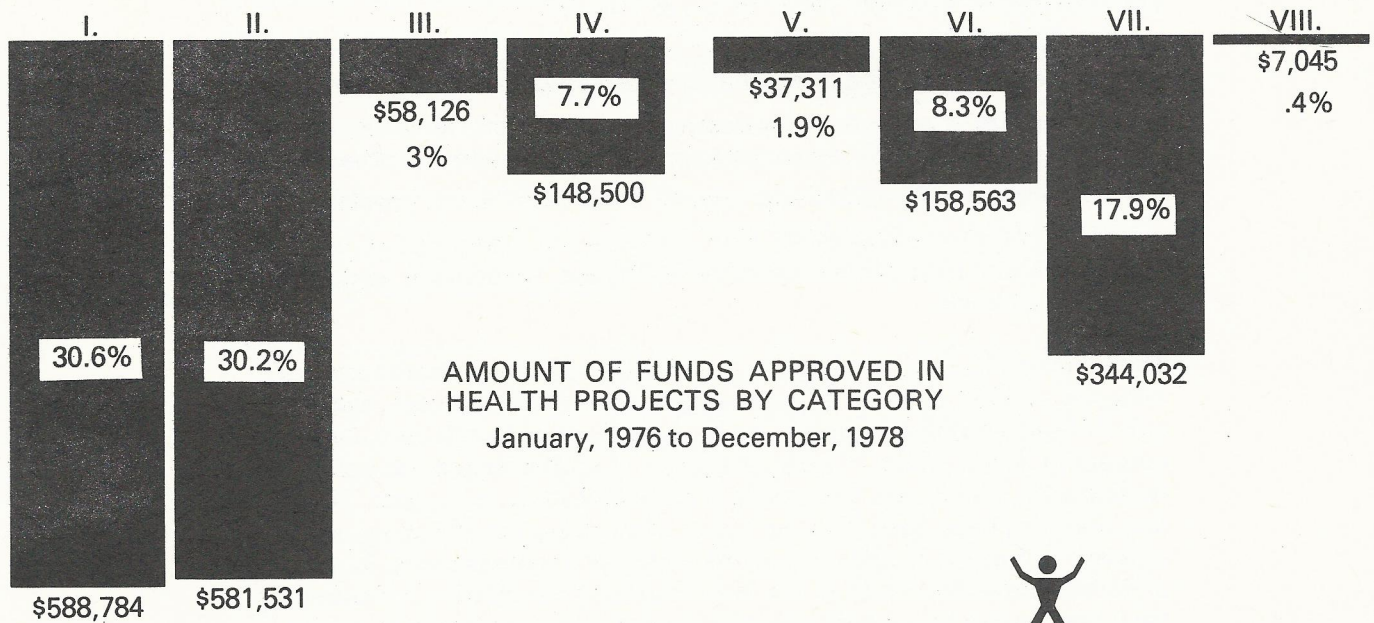
WHITMAN-RADCLYFFE FOUNDATION, San Francisco; An information and referral/counseling center directed for and by homosexual problem drinkers. $12,000 (11-76) — (MH/EHE)

CLASSIFICATION OF SAN FRANCISCO FOUNDATION HEALTH GRANTS — 1976 to 1978

On the following page is a graph showing the numbers of grants and the amount of money granted in the eight health categories defined. If a project was listed in only one category, this category received one full point and the full amount of money. If a project was listed in two categories, each category received one-half point and one-half of the money.

The graph clearly shows that The San Francisco Foundation has given a large majority of its grants and grant money in health to projects oriented towards providing health services, as compared with projects oriented towards health education and health promotion.





AMOUNT OF FUNDS APPROVED IN HEALTH PROJECTS BY CATEGORY
January, 1976 to December, 1978

THE SAN FRANCISCO FOUNDATION

Part III: The San Francisco Foundation's directions for the future

There is a variety of choices that a foundation can select in allocating funds to health projects, ranging from laissez faire to total planning approaches as well as from strictly health related projects to projects that are only indirectly related to health. At this point it is appropriate to begin to talk about what possible approaches The San Francisco Foundation can take.

PRESENT HEALTH PRIORITIES

One choice is that The San Francisco Foundation can maintain its established health priorities. When this writer talked with Foundation staff about past health projects, many were considered very successful in reaching intended objectives, a few were considered mildly successful, and only a couple projects were considered unsuccessful. However, even though most projects were successful, The Foundation can appreciably improve its grant giving to health projects. One basic question that arises is: how can The Foundation fund the greatest number of successful programs while still maintaining quality in program development, implementation, and evaluation? Simply, how can The Foundation's funds be used in the most cost-effective manner.

The Foundation's present priorities are as follows:

Primarily concerned with organized efforts to meet the health and medical care needs in pluralistic forms that are both efficient and effective.

- Emphasize organization and management of health services, such as combining of health resources to promote efficiency and effectiveness.
- Support projects addressing specific and critical health problems
- Promote efforts to evaluate new methods and categories of professionals and para-professionals in health care, particularly emotional/mental health.

The Foundation's present health priorities are basically oriented towards reducing medical care costs, improving quality of medical care, aiding critical health problems, promoting new methods of health care, and encouraging development of new categories of professionals and para-professionals in health care (especially in mental health). In the past, Foundation priorities have been directed toward improving the effectiveness and efficiency of medical care institutions and health professionals. It is thus understandable that most of The San Francisco Foundation's health grants have been going to projects oriented toward *direct treatment by professionals* rather than towards *direct health education/promotion of indi-*

viduals (as shown in Part II of this report). As important as medical care is, it should be recognized that such an approach tends to be an expensive investment often with short-term benefits.

RECOMMENDED NEW HEALTH PRIORITIES

The following are health priorities recommended to The San Francisco Foundation (italic indicates changes from old priorities):

Primarily concerned with organized efforts to meet the health and medical care needs in pluralistic forms that are both efficient and effective *in promoting personal and public health.*

- Emphasize organization and management of health services, such as combining of health resources and *involvement of citizens in developing health policy* to promote efficiency and effectiveness.
- Support projects addressing specific and critical health problems *when promotive and/or preventive measures are incorporated into health care delivery.*
- Promote efforts *to utilize* and evaluate *promotive and preventive measures* and new categories of professionals and para-professionals in health care.*

**Promotive measures:* educational or treatment approaches that predispose, enable, and/or reinforce greater responsibility of the individuals for their own health.
Preventive measures: educational, environmental, or treatment approaches that are oriented towards decreasing the probability of a specific disease.

A basic philosophy of The Foundation is to provide seed money to community projects. Many foundations try to instill in grantees a capacity for self-sufficiency. *This self-help philosophy is an important value for grantees to have for their constituency as well.* Community services can be given away and soon depleted, or community services can be oriented towards teaching people to do something for themselves so that they will no longer need the community service in the future. This latter approach is obviously preferred and is recommended to be established as a San Francisco Foundation priority. In considering new health priorities, it is important for The Foundation to consider funding projects oriented towards addressing critical health problems, however, this report recommends that priority be given to those projects that integrate health promotion practices into addressing health care problems.

Health promotion refers to a wide range of lifestyle and behavior factors that are determinants to health and that are within the control and responsibility of the individual. These health related factors include, but are not limited to, eating habits and diet, consumption of alcohol, use of tobacco, management of stress, physical exercise, and attitude and emotional state. Health promotion is, thus, not oriented towards the health professional; it is oriented towards the person seeking health. As such, health promotion makes use of the most underutilized and least expensive

health care resource today — the individual. It should also be recognized that individual responsibility for health has potential for health benefits that cannot be matched by present medical technology.

More participation of the individual in his own health is an idea whose time has come and is reflected in the following three quotes by John H. Knowles, President of the Rockefeller Foundation, Walter J. McNerney, President of the Blue Cross Association, and Joseph A. Califano, Secretary of Health, Education and Welfare:

> "The next major advances in the health of the American people will come from the assumption of individual responsibility for one's own health and a necessary change in life style for the majority of Americans." — John H. Knowles, M.D.

> "We must stop throwing an array of technological systems at life style problems. We need public and private support to test new approaches to health and new measures aimed at giving people the capability and will to take greater responsibility for their own health." — Walter J. McNerney.

> "We must replace our prevailing ethic of expensive self-indulgence with an ethic of rigorous personal responsibility. Government cannot enforce it. Doctors cannot administer it like a drug. We face a choice between taking increased responsibility for our own health and continuing the present wasteful sick-care system, with its staggering toll in dollars, wasted lives and grief." — Joseph A. Califano.

Getting individuals involved in their own health can result in a series of benefits to the individual and the health care system. Taking greater responsibility for one's own health may mean many different things to different people. To some people it may mean eating a nourishing breakfast or avoiding certain foods, getting more exercise or learning how to relax, getting out of an unsatisfying relationship, changing jobs or improving one's present job, learning where nearby health facilities are or questioning the physician's advice.

Although ten years ago there was not much research in the field of lifestyle and health, there is a growing body of literature that is showing the effects of our lifestyle on our health. A well-known study of 7,000 Californians by N.B. Belloc and Lester Breslow, Dean of U.C.L.A.'s School of Public Health, demonstrated that people who followed the following seven key health habits lived an average of eleven years longer than the average person: eating breakfast, exercising regularly, maintaining a normal weight, abstaining from cigarettes and heavy drinking, sleeping eight hours a night, and avoiding between-meal snacks.[27]

Getting people involved with their own health has possibilities for improving their own health as well as for reducing medical care costs. Keith Sehnert, M.D. and author of a well-known book on self-care called "How to Be Your Own Doctor (Sometimes)", started "an activated patient program" at Georgetown University School of Medicine. In a recent study through this program, Dr. Sehnert discovered that simply by getting patients to ask their

physician about the necessity for certain lab tests or x-rays reduced such tests by 30%.[28]

Another benefit of getting individuals more involved in their own health care was discovered in a different study by Dr. Sehnert. He found that activated patients who take more control of their own health and health decisions tend to be more satisfied with their medical care.[29] The results of this and the previously mentioned study by Dr. Sehnert sheds light on how self-responsibility for health can prove beneficial to individuals and physicians.

It should also be noted that third party payors (insurance companies, Medicare, Medicaid, or pre-paid plans) and their large and growing number of clients can also benefit from health promotion programs. It is becoming increasingly logical for organizations to develop health promotion programs as a way to avoid excessive use of "free" medical services. Decreasing the payors' cost will ultimately also decrease the premiums to their clients (in the case of insurance companies and pre-paid health plans) and to society (in the case of government medical programs).

This report also recommends greater citizen involvement in policy decisions that affect individual and community health care. The case for the importance of citizen participation in health policy, in part, has been discussed. The federal government has instituted Health System Agencies (HSAs)* throughout the country with each local governing body comprised of a majority of consumers. The state government has also taken similar steps in this direction. The Board of Medical Quality Assurance (the state medical board) now has seven consumer members. Community-based clinics which are controlled by community representatives have sprung up throughout the Bay Area. Ten years ago Alameda County had only one community clinic. In 1977 there were 13 such clinics which served a majority of publically-funded primary care patients, a total of 3% or 37,000 patients.[30]

*It is recognized that the value of the Health System Agencies has not yet been proven. It is also recognized that the HSAs have sometimes wielded their power without enough sensitivity to established medical institutions. Still, the concept of getting the public involved in health policy could have great value to the community and should be adequately tested for its appropriate use.

Basically, the assumption for citizen involvement in health policy is that there will be improvement in the quality of health care decision-making and there will be an increase in the community's proper utilization of health care facilities. The basis of this improvement is that citizen involvement in decision-making will give an opportunity for diverse needs to be raised, varied opinions shared, and a democratic organization established.

One can recognize that the health priorities recommended are chiefly oriented toward the determinants of health that Lalonde calls Lifestyle and Health Care Organization. It is important to ask then what should The San Francisco Foundation do with the other two determinants to health: Human Biology and Environment. In reference to Human Biology, it is recommended that The Foundation continue to maintain a low priority on medical research. Such projects are rarely appropriate for community foundation funding.

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The Environment (physical and social) as a determinant of health should be a concern to The San Francisco Foundation. At present, there is a multitude of daily environmental stresses that directly or indirectly influence an individual's health. One area of concern that foundations are beginning to consider is occupational health.[31] The San Francisco Foundation may consider providing support to this field as well. A growing number of hazards are being associated with the workplace. A recent HEW report cited that according to conservative estimates approximately 20% of cancers are occupationally related.[32] The field of occupational health is a complex and difficult area for The San Francisco Foundation to fund because other sectors in our society, including the federal government, unions, and industry, are frequently in a better position to oversee and improve workplace conditions. There are issues, however, that these sectors are not providing the necessary leadership. The Foundation can then consider funding projects that attempt to more actively involve the federal government, unions, and industry in areas of serious concern which are presently neglected.

The major difference between the new priorities recommended by this report and with the existing ones is the emphasis on health promotion and health prevention forces. The San Francisco Foundation is in a position to advocate strongly for these approaches in health care. Foundations generally are in a position to influence health policy of public and private agencies. It is thus recommended that foundations, in particular, The San Francisco Foundation, take advantage of their status within the community to provide the leadership needed in health promotion and prevention — the step beyond treating disease.

EXAMPLES OF PROJECTS CONSISTENT WITH THE RECOMMENDED PRIORITIES

The following are examples of health promotion/prevention projects worth funding based upon the new priorities. It is recommended that The Foundation consider funding such programs provided that (1) the project has well thought-out program development, implementation, and evaluation, and (2) the project fits at least one of The Foundation's general priorities (projects directed toward the development of public policy, projects directed toward changing institutional behavior, projects which test new methods of addressing problems, projects which propose to coordinate or combine the activities of two or more established organizations, projects which enhance the enjoyment and appreciation of life through the arts, culture and the humanities.

(1) A consortium of patient education programs from hospitals, community clinics, and educational centers in the Bay Area.
(2) Health groups for employees based upon job related stress, job satisfaction, life stress, and development of stress management skills.*
(3) Health promotion programs within existing health care centers.
(4) Health education programs within social service agencies and community centers facilitated by volunteer health educators and various health practitioners.
(5) Educational and advocacy organization for improving specific environmental problems that affect health.

(6) A self-care support group for populations at-risk that could be evaluated, replicated, and assure cost-effectiveness.
(7) A self-care center in a low-income area, or in an area where there is a high concentration of elderly or a dual-language community.
(8) The utilization of biofeedback equipment in a facility for youth with emotional problems or with psychiatric disorders, or with healthy children in a classroom setting. (Biofeedback is beginning to be recognized as a therapeutic tool and as a teaching tool for instructing individuals how to control various bodily and mental functions.)
(9) An evaluation of an organized physical fitness program that could have implications on other agencies and businesses.
(10) Start-up costs for a nurses' training program in patient education and health education, with a special emphasis on self-care.
(11) Salary of clinic coordinator whose role is to get patients/clients involved in the clinic's health policies.

*Based upon a special HEW task force on "Work in America", work satisfaction was observed as the strongest predictor of longevity. *Work in America,* report of a special task force to the Secretary of HEW, Cambridge, Massachusetts, MIT Press, 1973.

PROBLEMS WITH RECOMMENDED PRIORITIES

Involvement of individuals in their own health and in health policy is only recently beginning to be considered by public agencies, private institutions, and the public. The San Francisco Foundation would thus be taking a risk by taking the position of supporting these new orientations in health care delivery. The Foundation could be criticized for supporting citizen involvement and health promotion/prevention measures that are unproven in their ability to raise health status. Further, if health promotion/prevention is given priority, the Foundation could be criticized for neglecting the health problems related to access medical care, especially for acute and surgical care.

The first criticism is appropriate. Health promotion/prevention measures are largely unproven in their ability to improve health status. However, many medical routine procedures also remain unproven or are controversial in their benefits. A recent report by the U.S. Congress' Office of Technology Assessment on "Assessing the Efficacy and Safety of Medical Technologies" concluded that "only 10 to 20 percent of all procedures currently used in medical practice have been shown to be efficacious by controlled trial."[33] Of course, this does not mean that all health promotion/prevention programs should be funded just because much of medicine also isn't fully proven. It means that although health promotion/prevention programs have not yet been proven, it may be extremely valuable to evaluate them because presently they are largely untested and because of great potential they have for long-term health benefit.

The public involvement in development of health policy is also untried and its possible effects unproven. However, the federal government considers consumer participation such an important experiment that it has created

Health System Agencies (HSA) throughout the country. HSAs serve local districts and influence federal dollars in relation to appropriate health expenditures.

It is interesting to add that a recent survey discovered that a significant number of HSAs have begun to define health promotion/prevention strategies for their community.[34] This is particularly astonishing considering that the government has not encouraged HSAs to take the initiative in promoting health.

The second possible criticism raises an important concern. If the Foundation adopts the priorities recommended, less money might go into programs that give access to acute medical care. The value of funding disease care versus health care has already been discussed. In view of the limited impact of the costly medical care system, individuals, institutions, and governments are now faced with the decision whether to spend money on disease care only or to establish a firm commitment to health promotion and prevention. As discussed previously, when the public has a part in health policy, they are beginning to take the initiative to encourage the development of health promotion/prevention programs. This report, likewise, encourages The San Francisco Foundation to make a commitment to health promotion/prevention.

Another criticism that could be raised is that there is only a limited number of individuals and agencies presently involved in health promotion/prevention programs. The Foundation may not get many good proposals fitting its new objectives. This criticism, however, is even further reason for the Foundation to take the leadership in health. Presently, the health promotion/prevention field is small; yet, the recent number of conferences throughout the United States and especially in the Bay Area and the number of reputable individuals (Hans Selye, Norman Counsens, editor of Saturday Review, George Leonard, former editor of Look Magazine, persons quoted in this report, and many others) involved in this approach portend an emerging significant change in health care.

If the Foundation accepts the recommended priorities, the staff and the Distribution Committee should be aware that health promotion programs can produce some negative side-effects. Self-responsibility for health, one of the main themes of health promotion and a very important concept in health care today, sometimes gets translated into meaning that the individuals are responsible for their illness also. This "blaming the patient" could tend to neglect genetic, political, economic and environmental influences that may be the primary factors in an individual's disease. Individuals involved in health promotion programs sometimes have a moralistic attitude that narrowly assumes that an individual's behavior is the primary determinant in all disease. The San Francisco Foundation staff and the Distribution Committee should be conscious of this blaming the patient in health promotion efforts so that Foundation funds can be invested in programs that truly promote a comprehensive and sensitive approach to health.

Another problem in some health prevention projects is particularly evident in diagnostic screening programs. Occasionally, such programs effectively reach their target population and offer the diagnostic information, however,

they sometimes do not and cannot provide the follow-up education, social service, environmental change, or medical treatment necessary to deal with the identified problem. In this case, diagnosis becomes a way that individuals identify themselves as "sick" and then tend to play out a sick and helpless role. The diagnosis of illness then tends to disable individuals further.

The Foundation can assure effective grant-making in this area by evaluating a project's follow-up activities. Also, The Foundation can consider giving lower priority to funding diagnostic programs that identify diseases or conditions for which significant improvement cannot be expected.

The San Francisco Foundation is not the only foundation to assume leadership in these fields. Kellogg Foundation has been very actively involved for many years. Last year alone they gave $7.4 million to health promotion programs. Locally, the Luke B. Hancock Foundation describes two of their three current interests as: "older adult services, education and administration in which the participant actively contributes to his/her own betterment, and medical and health activities, services, education and administration emphasizing the role of the individual in the care of his/her health."

Local and federal governmental agencies are beginning to get involved in health promotion. San Francisco's Health Department considers it so important that the health education department has been renamed the Bureau of Health Promotion and Education, and its position within the health department has been moved to a place within the Director of Public health's executive offices.

On the federal level, the U.S. Congress' Office of Technology Assessment has defined its six priorities, one of which is health promotion/health prevention. Also, in 1977 the federal Office of Health Information and Health Promotion was opened in part to begin to initiate and coordinate health promotion programs.

One of the most supportive statements for health promotion from the federal government came from HEW's Public Health Service. In their report on the "Forward Plan for Health (1978-82)", it stated, "absent any major scientific breakthrough such as a cure for cancer, the greatest benefits are likely to accrue from improved health habits rather than from further expansion of the health care system."[35]

These agencies involved in health promotion are not representative of the majority of local, regional, or federal efforts in health care. These agencies are but a few that are taking the leadership in supporting health promotion programs as one way to deal with the present crisis in health care. Indeed, involvement in health promotion is only just beginning to take place in our society, but it is beginning all over the country and on many levels of public and private enterprise.

TAKING THE INITIATIVE

In the past, The San Francisco Foundation has taken the initiative to actively pursue individuals and groups of people interested in organizing around a pressing need. The state of health of Americans and the state of our health care system is presently in critical condition. Although governmental agencies are now recognizing this ailing condition, they are very slow in moving towards positive change. Further, little desire to change is coming from established medical institutions. In a special report in Business Week (September 4, 1978)[37] it is noted that industry is beginning to take the lead in providing preventive and promotive health programs to its employees. Despite this positive action from industry, considerably more change is required to revive a healthier approach to health care. Foundations, specifically The San Francisco Foundation, are needed to provide a leadership in urging greater orientation towards health promotion and prevention and towards greater involvement of citizens in health care decision-making.

In order to begin to take this leadership, the Foundation can consider approving the priorities recommended in the report.

Appendix

BUILDING PROGRAM INTEGRITY

Projects that work to encourage healthier behavior and quality health care decision-making cannot expect to be successful by just offering health information and assuming that individuals or institutions will act appropriately with this knowledge. Nor can one expect positive change to occur by only making more health services available to people. One also cannot expect effective change by only establishing a means to support or reinforce the changed individual or institutional behavior.

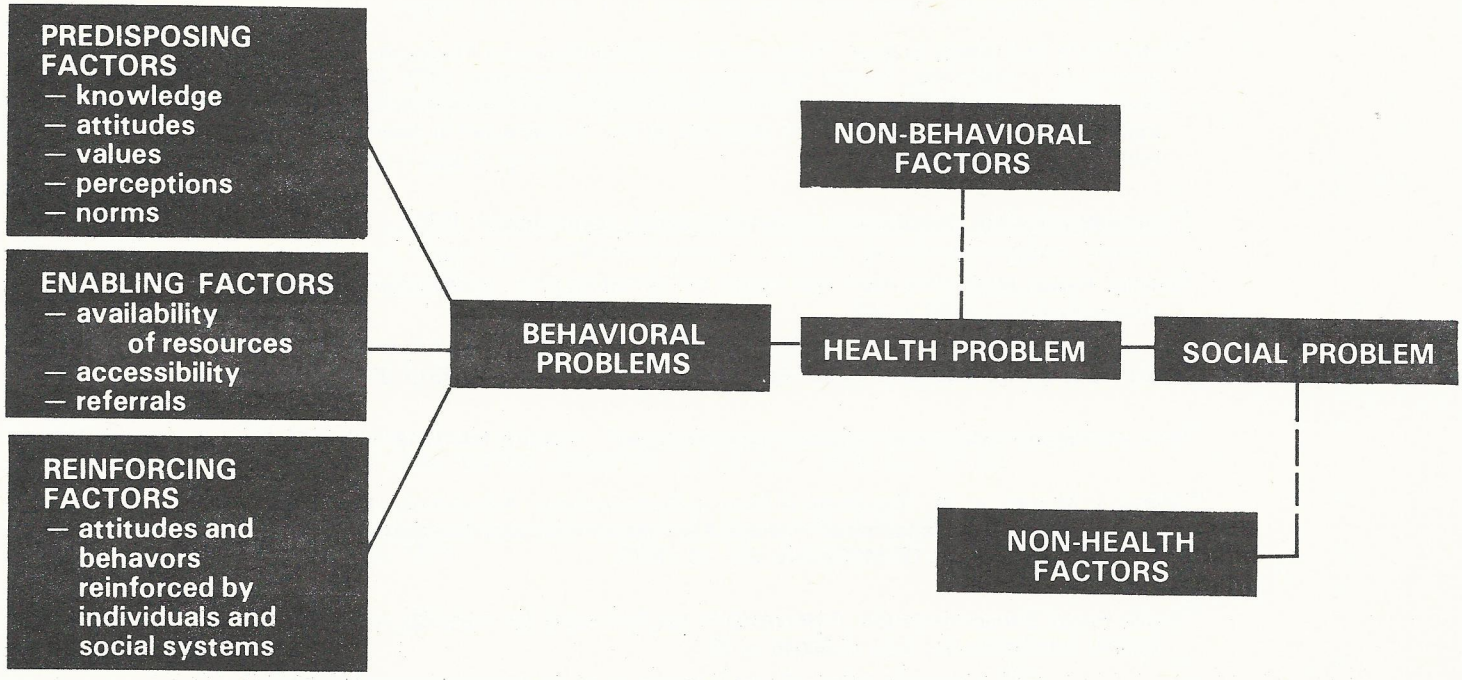
Lawrence Green, Dr.PH, Professor at Johns Hopkins and one of the foremost spokespersons in health education today, has created a model for developing effective programs that can change health behavior and that is transferable for changing institutional behavior. Integrating behavioral science, social science, and health education research, Dr. Green describes three important components that programs should have to promote and sustain healthy behavior.[36] These factors include using "presidposing", "enabling", and "reinforcing" factors within a program. *Predisposing factors* are preventive factors that reduce or eliminate causes of physical, psychological, or social stress that could have led to individual or social

stress. *Enabling factors* provide individuals, groups of people or institutions with tools for change after a problem already exists. *Reinforcing factors* lend support to the change process of individuals, groups of people, or institutions in order to foster long-term change. Programs that utilize all three of these factors can be thought to have *program integrity* and should be considered to have greater chances of outcome success. The Foundation can thus evaluate programs based upon the degree to which the program deals comprehensively with these three basic factors.

In this interest in program integrity and comprehensiveness, predisposing, enabling and reinforcing factors are included in this report's recommended priorities in the definition of health promotion.

The chart below illustrates the three components of program integrity and their ultimate effect on social problems:

COMPONENTS OF PROGRAM INTEGRITY



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