

From the Publisher

The Significance of the Milbank Memorial Fund for Policy: An Assessment at Its Centennial

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Milbank Memorial Fund

IN 1935, WHEN MEDICAL SOCIETIES ACROSS THE UNITED States were complaining that the Milbank Memorial Fund endorsed health insurance mandated and subsidized by government, Albert G. Milbank, president of its board, accorded priority to protecting the Fund's "reputation and its personality" (Kingsbury 1935a). This article, on the occasion of the Fund's centennial, describes how its personality, expressed in the values, priorities, and methods of its leaders, influenced its reputation among persons who made, implemented, and studied the results of health policy. Its theme is that the Fund has been most effective when it has been a broker of practical knowledge about policy for preventing and treating illness, organizing and financing health and related services, and protecting and enhancing the health of populations.

The Fund has been consistent in its goals, and in how its board and staff implemented them, for most of its history. Elizabeth Milbank Anderson, who donated its endowment between 1905 and 1920, described four goals in 1913 when she announced an initiative by the Fund and New York City's then leading social welfare organization to improve policy and practice aimed at the health and social welfare of the poor. The first goal was "fostering preventive and constructive social measures for

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The Milbank Quarterly, Vol. 84, No. 1, 2006 (pp. 5–36)
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the welfare of the poor.” The next was to “prevent sickness and thus relieve poverty.” The third was “cooperat[ion] with public authorities” and other philanthropies. Fourth, she believed it “prudent to devote some time and money to investigation and research” in order to assure that “any proposed measure will accomplish the object sought to be obtained” (Anderson 1913).

Two decades later, John A. Kingsbury, who had become the Fund’s first full-time chief executive in 1921, reiterated in his own words the goals Anderson had announced. The Fund, Kingsbury wrote, sought “improvement in the general level of public welfare and public health through the translation into practical usefulness of knowledge.” Such knowledge included principles that were “confirmed by experience” as well as “sustained by scientific research” (Kingsbury 1930).

Kingsbury’s longest-serving successors acted on the goals set for them in 1913. Frank Boudreau, chief executive from 1937 to 1961, explained that “our attempt has always been to improve the public health, to test methods and procedures, and [to] try to have them adopted eventually by the public health authorities” (Boudreau 1950).

In October 2004, proposing a program for my fifteenth year as president of the Fund, I told my colleagues on its board, “The Fund seeks to improve health by helping decision makers in the public, private, and nonprofit sectors use the best available evidence to inform policy for health care and population health” (Fox 2004).

Because this article is about the significance of the Fund for policy, it describes its institutional history only when necessary for context. The Fund’s centennial report provides a chronological history of its programs, leadership, and financial resources (Milbank Memorial Fund 2005a). The introduction to an anthology of articles from this journal describes its role in the history of the Fund (*Milbank Quarterly* 2005).

A New Foundation in New York City

The foundation that became the Milbank Memorial Fund in 1921 began its work as the Memorial Fund Association in 1905, during what historians call the Progressive Era. In the early twentieth century, leaders of business, government, and philanthropy across the United States believed that they shared responsibility for the health and welfare of the public, particularly the poor. These leaders believed that creating

opportunities for upward mobility was both their moral obligation and a way to increase the productivity of the workforce. One of them, Elizabeth Milbank Anderson, had since the early 1890s used some of the wealth that her father had accumulated as an investor to finance higher education for women and to promote collaboration between city government and private philanthropy in maintaining and improving health, especially for children (Kiser 1975). Between 1905 and her death in 1921, Anderson and her cousin, Albert G. Milbank, created, as a memorial to her parents, one of the earliest endowed foundations in the United States.

Albert Milbank, a lawyer, combined private practice with leadership in the Borden Company, the source of the family's wealth. In 1904 he was elected to the board of managers of the New York Association for Improving the Condition of the Poor (AICP), the city's largest private social service organization. Over the next several years, officials of city government appointed him to committees that oversaw joint projects between public agencies and the AICP.

John A. Kingsbury, who worked with Anderson and Milbank in their philanthropy, had come to New York City from the Pacific Northwest at the turn of the century to attend Teachers College of Columbia University, after which he became a member of the staff of the AICP. Kingsbury was a "Bull Moose Progressive" who worked in Theodore Roosevelt's third-party campaign for the presidency in 1912. From 1914 to 1918 Kingsbury was the city's commissioner of public charities. In that position he disbursed, a contemporary wrote, "more [public] money for charitable purposes than any other individual in the world" (Howe 1915).

The AICP implemented the major projects of the Memorial Fund Association. During its sixteen years, the Association devoted almost two-thirds of its total philanthropy to public health, clinical services, and child welfare in New York City and State. The AICP managed at least 60 percent of this money, closely supervised by Anderson, Kingsbury, and Milbank (Kingsbury 1919).

Three of the projects the AICP managed for the Association shaped the future Milbank Memorial Fund: the Milbank Baths, the New York Commission on Ventilation, and the Home Hospital for persons with tuberculosis (TB) and their families. In each of these projects the AICP assisted policymakers in assessing and adapting methods for improving the health and welfare of the poor, which had been developed and tested successfully in other cities in Europe and the United States.

Since the early 1890s, the AICP had urged city government to build large facilities for public bathing in order to prevent disease among the poor by improving their hygiene. In 1901, at the request of the AICP, Elizabeth Milbank Anderson purchased a site on East 38th Street in Manhattan on which to build a model bathhouse. In the mayoral campaign of 1903, each of the candidates endorsed expanding the city's rudimentary public baths; Anderson then pledged funds to AICP to construct a building that would accommodate 3,000 bathers a day. Through the AICP, Anderson and Albert Milbank monitored the construction of the baths and their operation by the city. With assistance from Kingsbury, they pressed city officials to build more baths and to achieve higher standards of "economy and efficiency" in managing them. In 1913, they proposed that the city add to the bathhouses public laundries, run "on a business basis," similar to those in several European cities (Kingsbury 1919).

John Kingsbury and Albert Milbank also advised New York State policymakers, both directly and through the State Charities Aid Association (SCAA). In 1912, for example, they helped persuade Governor William Sulzer to appoint a commission to reorganize the state health department. The commission's report included a recommendation to establish a policymaking body, the Public Health Council, comprising appointees from government, philanthropy, and health services; this Council continues to the present.

For the New York Commission on Ventilation, which began in 1913 and continued until 1923, the young foundation subsidized a synthesis of available scientific evidence and commissioned new studies intended to inform health policy. In 1913, at the request of Kingsbury and Milbank, the AICP recommended that Governor Sulzer appoint a commission to assess the science bearing on ventilation policy in new school buildings. The governor charged the commission to resolve a debate about whether fresh air to prevent respiratory illness among children was supplied most effectively by air-changing equipment or by increasing access to fresh air through the design of windows, or by some combination of the two methods.

The Commission on Ventilation and the Memorial Fund Association sponsored research in laboratories and under classroom conditions in four states. These studies persuaded policymakers in New York and other states to mandate the number and design of classroom windows and exhaust ducts along with the maximum number of students that could be taught in each room.

The Association, now the Milbank Memorial Fund and again in partnership with New York State officials, appointed another commission in 1926, because “nearly half” the states had not adopted regulations based on the research it had previously sponsored. Research conducted for this commission found that children taught in classrooms that relied mainly on window ventilation for fresh air had markedly less respiratory disease than those whose classrooms depended mainly on mechanical ventilation. The commission recommended that state regulations for school construction be modernized by specifying “hygienic results to be obtained” rather than “engineering devices to be used in their attainment” (New York State Commission on Ventilation 1931).

The Home Hospital, initiated in 1912 by Kingsbury as the general agent of AICP with funding from the Memorial Fund Association, pioneered a recently developed approach to organizing care for low-income persons with TB, then the leading cause of death in the United States. Most patients with low incomes and active cases of TB lived at home, “without adequate medical supervision or social service,” reported AICP staff. In the Home Hospital project, patients with TB moved with their families into model tenements constructed in 1909 with the help of a gift from Mrs. W.K. Vanderbilt Sr. The patients were given as “complete as possible isolation” in order to limit their spreading the disease; their families received food and living allowances. Patients and their families were “under the constant supervision of a resident nurse,” in addition to that of physicians and social workers (Kingsbury 1919; Kiser 1975).

The Fund and the Politics of Public Health Reform

By 1920, Kingsbury and Albert Milbank, like many other Progressives, had concluded that access by the poor and the working class to essential medical services was necessary to assist their upward mobility and to improve their productivity at school and work. But most projects that demonstrated the value of improved access to care, like the Home Hospital and a similar project established by the Metropolitan Life Insurance Company in Framingham, Massachusetts, were too small and labor-intensive to convince policymakers to replicate them on a larger scale.

Kingsbury and Milbank’s first initiative as leaders of the renamed Milbank Memorial Fund sought to demonstrate the benefits of offering

integrated health and social services to entire communities in New York State. These demonstrations emphasized the prevention and treatment of TB but also included care for pregnant women, preventive services for infants and children, and the early discovery of cancer and what they called “cardiac difficulties” (Kingsbury 1921a; Kingsbury 1923; Kiser 1975).

Kingsbury and Milbank applied to these demonstrations knowledge about the politics of health policy that they had acquired as collaborators for almost two decades. They focused the projects on carefully defined populations, diseases, and services so that the goals would be clear and the results measurable. To manage the demonstrations, they created a technical board of national experts in medicine and public health to serve as a liaison between “appropriating bodies [government and philanthropies and] the operating agencies” at the demonstration sites. Kingsbury described the Technical Board as a “close analogy to the Board of Estimate and Apportionment” that allocated funds among agencies of government under New York City’s charter.

In order to distance itself from the inevitable disputes about funding, the Fund appointed the leading philanthropic coordinating agencies in the state, the AICP and the SCAA, as fiscal agents for its contributions to the demonstrations (Kingsbury 1921b). Most important, they worked closely and confidentially with New York State Health Commissioner Hermann M. Biggs, one of the most influential public health officials in the nation, as well as with political leaders in each of the three demonstration communities: rural Cattaraugus County, New York City, and Syracuse.

Executives of the Rockefeller Foundation, underestimating Kingsbury’s and Milbank’s experience in the politics of policymaking, advised John D. Rockefeller Jr. to decline an invitation from his school friend Albert Milbank to join in financing the demonstrations. Rockefeller Foundation president George Vincent assured Rockefeller that philanthropists could not do business with politicians. “The [negative] attitude of the [New York] city administration toward foundations is well known,” he wrote, without supplying any evidence to that effect. Vincent’s staff predicted that the mayor and the city’s health commissioner would “resent so spectacular an attempt to aid a large number of the city’s sick and dependent”; as a result, these officials were likely to “hamper and discredit the undertaking.” Moreover, seeking to improve

nutrition, health services, and access to recreation for people with low incomes was controversial. It would “raise the question of the standard of living, distribution of wealth—the whole social question” (Vincent 1921).

Kingsbury, Milbank, and their allies in city and state government as well as in philanthropy intended to raise the “whole social question.” They believed that if the health of people in the demonstration communities improved they would become happier and more productive students, parents, and workers. As voters and as prospering citizens these people would reelect the public officials who had improved their standard of living. These officials, in turn, would be more amenable to evidence and advice offered by foundations.

Hermann Biggs had more insight into the politics of New York City and State than did the Rockefeller Foundation staff. Two decades earlier, as chief physician of the New York City Department of Health, Biggs had implemented reforms that attracted worldwide attention. Much of his success was a result of both his service as the personal physician to the leader of Tammany Hall and his decision to pay, as part-time city employees, physicians in private practice who examined children in the public schools (Fox 1975). In January 1922, Biggs wrote Kingsbury that the Fund’s demonstrations would link science and practical politics because they would “definitely determine whether TB can be controlled; and if so, at what cost” (Biggs 1921).

Many books and articles assessed the demonstrations, which continued for a decade. These publications documented the effects of the new services in each of the three communities and the influence of each of the demonstrations on health policy in New York State and nationally. The demonstrations also attracted favorable attention, locally as well as nationally, from the press and from public officials (Bache 1934; Grout 1936; Hiscock 1936; Winslow 1931 and 1934; Winslow and Zimand 1937).

The authors commissioned by the Fund, as well as writers in newspapers and magazines, missed the significance of the demonstrations because they regarded them as innovations rather than as attempts to take small projects to scale. Advocates of health reform had been urging the establishment of county health departments and district health centers for several decades. Home health care by trained nurses originated in the nineteenth century. The Fund’s leaders knew better than to claim that these services were new; if the services had

been untested, policymakers would be wary of them. Rather, Kingsbury and Milbank brought innovations in policy that had been effective in smaller settings, often without support or subsidy from government, to the attention of public officials who had the authority and resources to institutionalize them. Unlike many other demonstrations, then and subsequently, which exhibited new techniques, the Fund demonstrated ways to scale up effective interventions as well as what can go wrong in the translation of attractive ideas into policy and practice.

Moreover, contemporary publications and later accounts by professional historians did not describe how Kingsbury, Biggs, the members of the Technical Board, and executives of the AICP and SCAA managed the politics of the demonstrations (Rosen 1971; Toon 1999). The sensitivity of their managers to the nuances of politics distinguished these demonstrations from similar but smaller projects around the country described by historian George Rosen as the “first neighborhood health center movement” (Rosen 1971). The Fund and its partners were careful to make their expectations explicit in negotiations with local authorities. They left local political problems to the locals—helping them to understand, in private, what was at stake. During a typical crisis, Biggs insisted that the Technical Board and SCAA “and all outsiders . . . leave the Syracuse people largely alone.” The Fund and its partners also insisted that “local officials and local organizations should have all the publicity,” especially when it was favorable (Biggs 1923).

The Fund and the Technical Board worried about negative publicity. A crisis occurred, for example, when the Cattaraugus County Medical Society denounced the demonstration in the mid-1920s: The director of the new health department had fired several Medical Society members because they refused to undergo training in methods to prevent infectious disease. The Technical Board discussed the crisis for seven months. One member feared that the “publicity . . . may retard the establishment of county health units elsewhere in the state and nation.” Another disagreed, arguing that conflict with local physicians was “necessary for progress.” In the end, the Technical Board sent a nuanced message to the County Board of Supervisors: The demonstration would continue, but only if the supervisors negotiated a truce with the Medical Society and increased the budget for the health department for the coming year (Technical Board 1927).

The Fund and the Politics of Financing Health Care

By the late 1920s, Kingsbury wanted the Fund to accord priority to lowering financial barriers to access to health services, then as now the most controversial issue in health policy. In 1927, the Fund and New York governor Alfred E. Smith, a contender for the Democratic nomination for president the next year, convened a conference to promote the creation of county public health departments modeled on the one in Cattaraugus County. Smith defined public health, in words that Kingsbury may have written, to include the financing of health care: “clinical services, laboratory services, nursing services, an education program for the prevention of disease, [and] opportunity for better treatment . . . suited to the needs rather than to the pocket book” (Smith 1927).

That same year the Fund joined three other foundations as initial supporters of the Committee on the Costs of Medical Care (CCMC), which issued research reports and, in 1932, controversial recommendations. The CCMC’s charge was to “study the economic aspects of the prevention and care of sickness, including the adequacy, availability, and compensation of the persons and agencies concerned” (Engel 2002). The CCMC had both medical and public members and was endorsed by the American Medical Association. Its chairman, Ray Lyman Wilbur, a former medical school dean, a year later became secretary of the interior (the department that then housed the Public Health Service) in the administration of President Herbert Hoover.

By 1931, Kingsbury and the Fund were more aggressively addressing the affordability of health care. The Fund’s increasing attention to financial barriers to care was in part a response to unemployment during the deepening economic Depression. After spending hardly any of its income from investments to aid individuals during its first quarter century, the Fund between 1930 and 1932 reluctantly contributed just over \$600,000 from its capital of approximately \$10.5 million for the relief of unemployed persons in New York City (Milbank Memorial Fund 1931).

Kingsbury insisted that relief alone, however, would not solve the problem of access to health care. He told the Fund’s board, whose members agreed with him, that the “existing economic system is such that a very considerable proportion of the people cannot pay for even the minimal services and environment necessary to the maintenance of health” (Milbank Memorial Fund 1931).

To prepare for a wider debate on health policy, Kingsbury commissioned Sir Arthur Newsholme, who had been the chief medical officer of a predecessor department to Britain's Ministry of Health, to write a series of books on policy for health services and public health in various countries (Newsholme 1932). Kingsbury also joined Newsholme and photographer Margaret Bourke-White in an inspection of health services in the Soviet Union that resulted in a laudatory book, *Red Medicine* (Newsholme and Kingsbury 1933).

In 1932 and 1933, Kingsbury and the Fund became involved in a national controversy about payment for health care. The majority of the members of the CCMC, in their final report late in 1932, endorsed the reorganization of health services by combining hospitals and physicians' practices. The new units would be financed by insurance premiums (called prepayment). The American Medical Association (AMA) denounced the report as a threat to autonomous medical practice and to the confidential relationship between physicians and their patients. Edgar Sydenstricker, the Fund's research director and a member of the CCMC, dissented from the majority because it did not, he believed, take full account of the overwhelming evidence that justified wholesale reform of policy for health care and public health. Kingsbury advertised the Fund's endorsement of policy that was even more radical than that of the majority of the CCMC by hiring I.S. Falk, who had been a senior staff member of the CCMC. Falk was an articulate advocate of mandatory health insurance with subsidies for persons with low incomes (Engel 2002).

The election of Franklin D. Roosevelt as president in 1932 gave Kingsbury and the Fund an opportunity to influence national health policy. Kingsbury had worked with Roosevelt and the new secretary of labor, Frances Perkins, in New York State; Harry Hopkins, who led the federal relief effort, had been a protégé of Kingsbury's at the AICP early in his career. When he was governor of New York, Roosevelt had in 1930 appointed Kingsbury to a new health commission. A month before Roosevelt was inaugurated as president, Hopkins described to the Fund's Technical Board his plans for the new Temporary Employment Relief Administration (TERA). At the same meeting, Thomas Parran, New York State health commissioner and a member of the Technical Board (and soon appointed by Roosevelt surgeon general of the United States), described how he proposed to use TERA funds to finance "medical relief" in New York State (Technical Board 1933).

Kingsbury's first contacts with the New Deal were encouraging. In July 1933, he telephoned Herbert H. Lehman, Roosevelt's successor as governor of New York, to volunteer to talk to Interior Secretary Harold Ickes, a friend from Theodore Roosevelt's 1912 campaign for president, about how the state could use the new federal public works program to construct hospitals. Harry Hopkins told Kingsbury that the "president is the . . . only man who knows what is actually going to happen" and urged him to write to Roosevelt (Kingsbury 1933; Hopkins 1999). In response, Kingsbury sent the president reports by Falk and Sydenstricker and anticipated visiting him in Hyde Park or Warm Springs to discuss a "national health plan." Roosevelt replied that "by next winter [1933–1934] it will be time for us to take up the general health problem from the national point of view" (Roosevelt 1933; Kingsbury 1934).

But Roosevelt soon distanced himself from advocacy for health insurance, because he feared that controversy about it would jeopardize support for his highest reform priority, social insurance for retirement pensions. He also cooled toward Kingsbury when the AMA and several state medical societies attacked the Fund for advocating "socialized medicine."

Some of the medical society leaders who attacked the Fund urged physicians to discourage mothers from using Borden's evaporated milk in infant feeding formula. Albert Milbank chaired the board of the Borden Company, and a substantial percentage of the Fund's assets was invested in Borden stock (Engel 2002; Milbank 1935). These attacks intensified during 1934 and early 1935 after Kingsbury, at Hopkins's request, assigned Falk and Sydenstricker to assist the cabinet-level Committee on Economic Security (CES) in writing proposals to include a subsidy for health insurance in what became the Social Security Act of 1935 (Kingsbury 1935b).

The president, meanwhile, maintained his distance from health insurance. In his message to Congress early in January 1935 proposing a social security program, he recommended expanding public health services but only studying the issue of health insurance. Hopkins still hoped to persuade the president to support some form of nationally supported health insurance, however. A few weeks later he invited Kingsbury and his staff to draft an insurance bill that would subsidize premiums for low-income persons. Senator Robert La Follette of Wisconsin would introduce the bill, he said. "Never mind the doctors or others," Hopkins

told Kingsbury. “Draft something that has some chance of going through in a year or two—and do it pretty quick” (Kingsbury 1935c).

In March 1935, however, the board of the Fund abandoned both public advocacy for national health insurance and John Kingsbury. Although Albert Milbank had received favorable national publicity for a speech and subsequent article defending the Fund’s advocacy of government-subsidized health insurance as based on objective evidence, he was, with other members of the board, increasingly uncomfortable with the public advocacy of Kingsbury and his staff. After organized medicine succeeded in killing or postponing national health insurance, the board decided that Kingsbury’s advocacy had become a liability for the Fund.

Albert Milbank had additional concerns about Kingsbury’s actions. Some of his discomfort was a result of “having to choose between the Fund and the Borden Company.” More importantly, he had decided by the fall of 1934 that the Fund had “departed from a strictly scientific attitude when we began to address the tremendous problem of health insurance.” He accused Kingsbury, as the latter wrote in a memorandum to the file, of “hiding what you and the staff want to do . . . under the word *studies*” (Kingsbury 1935a).

Milbank and Kingsbury disagreed, for the first time, about how the foundation should inform the politics of policymaking for health. Each of them had held strong opinions about controversial questions of policy during three decades of association. But they had insisted that public statements by the Fund should emphasize the implications of the most authoritative evidence for policy. Moreover, they believed, the Fund should only advocate policy that already had some support among leading public officials; to be radical was to risk irrelevance. In the controversy over health insurance, according to Kingsbury’s summary of their conversations, Albert Milbank concluded that Kingsbury had changed the Fund’s approach to politics. Kingsbury was “attempting to go before the public with our conclusions and views, which our opponents characterize as propaganda” (Kingsbury 1935a).

Albert Milbank and John Kingsbury had once agreed that effective brokers of ideas to policymakers must be credible. Milbank could not avoid the evidence that the Fund’s claim that national health insurance was justified by scientific research was not perceived as credible either by the president of the United States or by organized medicine.

Kingsbury had prioritized the issue of health insurance over the protection of the Fund's reputation. In the private meeting in which he asked Kingsbury to resign, as reported by Kingsbury, Albert Milbank worried about "legislative investigation of foundations," whether the Fund could maintain enough income from other investments to continue its program if it divested itself of its Borden stock, and whether other aspects of its program—studies of women's fertility, for example—could become controversial. Kingsbury agreed that his primary interest had become "people who are without medical care." "During these . . . years of crisis," he told Milbank, "you have been moving more to the right while I have been going more to the left" (Kingsbury 1935a).

Research to Inform Policy

Neither Albert Milbank nor the board, however, wanted Kingsbury's departure to signal the Fund's retreat from engagement with policy and policymakers. Albert Milbank wanted to avoid "defining too rigid a policy" about how and when the Fund should address controversial issues (Kingsbury 1935d). Samuel R. Milbank, his son and, later, successor as the presiding officer of the Fund's board, said during a confrontation between Kingsbury and the board late in 1934 that "I think there will always be times when we will see a situation that could be cured or changed for the better and we may again have to take the position of the protagonist" (Fox 1993).

By coincidence, the Fund embraced another controversy in the same week that Kingsbury resigned. At its annual conference, as a headline in the *New York Herald Tribune* declared, "For the First Time . . . [the Milbank Memorial Fund] Devotes a Round Table to Problems of Venereal Disease," a subject then usually not discussed in public (*New York Herald Tribune* 1935). The same year, for instance, a national radio network would not permit Surgeon General Parran to use the word *syphilis* on a broadcast.

Albert Milbank and the board sought a successor to Kingsbury who had a strong reputation in science as well as in health policy. They first appointed Edgar Sydenstricker, who had been an innovative epidemiologist with the United States Public Health Service and then at the Fund. As his criticism of the CCMC majority report made clear, Sydenstricker was also a strong proponent of mandatory health insurance with

subsidies for low-income persons. But Sydenstricker died unexpectedly within a year.

The board then appointed Frank Boudreau, who served for the next quarter century. An American who was born in Canada and educated in medicine and statistics in that country, Boudreau became a public health official in Ohio and then joined the League of Nations Health Organization (LNHO) in Geneva in 1925, where he rose to become deputy director.

As an international civil servant, Boudreau was experienced in avoiding public controversy while developing policy and helping policymakers to implement it. From Geneva, he had participated in research on indicators of health conducted by the Fund. This research helped to justify what historian Paul Weindling describes as an “international consensus among public health experts” that “whatever the prevailing political system . . . the collectivization of health care was inescapable and should be informed by advances in the biological and social sciences.” Under the auspices of the LNHO, this consensus and the research that strengthened it led to a “new concept of ‘positive health’” by the late 1930s (Weindling 1995).

Advocates of this concept—pioneers in the new and struggling specialty of social medicine—accorded priority in health policy to preventing or at least postponing disease and disability by addressing such broad determinants of health as nutrition, income, housing, and the environment. Social medicine attracted very few adherents compared with clinical specialties and had difficulty becoming institutionalized in most countries.

Because of this weakness, many of the physicians who chose careers in social medicine in Europe and the United States in the 1930s and early 1940s, Boudreau among them, found it prudent to avoid controversial public debates about how physicians’ services should be organized and financed. Boudreau focused the program of the Fund on research and policy to promote positive health in three areas: food and nutrition, demography, and population (the latter a euphemism for studies of fertility and methods of birth control), and the epidemiology and treatment of mental illness in communities.

Boudreau’s political style was similar to what Kingsbury’s had been from the inception of the Fund until the early 1930s. He devoted considerable time to maintaining cordial relationships with policymakers and researchers, sought opportunities to assist in crafting new policy,

and used the Fund's publications to disseminate new information that exemplified its commitment to objectivity. Like Kingsbury, he used Technical Board meetings as seminars to which he would invite both decision makers and researchers. In annual conferences, the Fund encouraged researchers to pursue new areas of inquiry and policymakers to assess the implications of new research findings.

Boudreau demonstrated his commitment to social medicine as well as his approach to politics at his first annual conference in 1937, shortly after he joined the Fund. He introduced the subjects of nutrition and housing "in their relation to health" and announced a grant to the American Public Health Association to establish a "committee on the hygiene of housing" to conduct research and recommend improved policy (Boudreau 1938).

At the conference in 1938 he described the program of positive health endorsed by his international colleagues in social medicine. "The scope of public health work is widening," he said, "to include such subjects as cancer prevention, adult hygiene, housing, nutrition, and the control of diseases such as syphilis and gonorrhea." He embraced the commitment of his colleagues in social medicine to collective action to improve health as well as their dedication to improving the scientific basis of health policy. Solving health problems, he said, "require[s] the formulation of a health program based on national requirements . . . and apply[ing] new knowledge [that recognizes the] interrelationship between all branches of social science" (Boudreau 1938).

Boudreau eagerly continued the Fund's work on population, adapting it to his vision of positive health. The Fund's research on the polarizing subjects of fertility and birth control had begun in 1928, when Sydenstricker joined the Fund to lead its research and hired demographer Frank Notestein. A member of the Fund's board, Thomas Cochran—a prominent banker at the J.P. Morgan Company—insisted that each of its projects in public health should include birth control services. Kingsbury, a friend and neighbor of Margaret Sanger, the pioneer birth control advocate, eagerly agreed (Kiser 1971; Notestein 1971).

Albert Milbank was interested in the relationship between demography and policy in international affairs as well. In 1936, before Boudreau's appointment, a grant from the Fund established an Office of Population Research at the Woodrow Wilson School of Public and International Affairs at Princeton University, where Albert Milbank was an active alumnus. According to historian Simon Szreter, Milbank was concerned

that the “School lacked expertise in the demographic dimension of the foreign affairs problems which it addressed” (Szreter 2005).

In three editions of her history of the politics of birth control, Linda Gordon asserts that, from the 1920s to the 1950s, the Fund was “one of the main backers of eugenics”—that is, of controversial policy to encourage the conception of biologically fit children and discourage the birth of the unfit—among “corporate foundations.” Gordon admits that most of the eugenicists in the American birth control movement were “moderates and liberals” who did not share the “racism, vicious coercion, sadism, and militarism of Nazi eugenics and [of] more than a few American contemporaries.” But she criticizes the Fund (along with the Carnegie Corporation of New York, the Rockefeller Foundation, the Population Council [see page 21], and agencies of the federal government) for encouraging birth control policy that had any purpose other than according women full autonomy over their right to reproduce—what she calls their “moral property” (Gordon 2002).

Neither the Fund nor its senior staff, however, promoted birth control as a means of preventing the birth of children who had what anyone defined as undesirable biological characteristics. Kingsbury accorded priority to understanding “economic factors particularly affecting the birth rate and birth control” (Milbank Memorial Fund 1931). In 1931, the Fund commissioned Raymond Pearl, a prominent biostatistician at the Johns Hopkins University who was also a eugenicist, to study contraceptive practices among 30,000 women (Kiser 1943; Pearl 1939). Pearl’s study led him to reject a eugenicist interpretation. He found that birth control had not increased the proportion of persons whom he considered to be unfit in this population. Moreover, in 1938 a researcher on the staff of the Fund publicly protested the deletion from a report by a committee appointed by the federal government of a statement disassociating the Fund from eugenicists (Notestein 1971).

The Fund under Boudreau was, however, involved in research and the development of policy that linked birth control to economic development rather than to women’s rights alone. During and after World War II, staff in the Office of Population Research at Princeton, who were paid by the Fund and by other foundations, formulated a theory of “demographic transition.” In 1945, Frank Notestein, who had moved from the Fund’s staff to direct the Office, and Kingsley Davis published what Szreter calls the classic formulation of the theory (Szreter 2005). They had initially

presented the theory at meetings that Boudreau had helped organize to discuss policy for both nutrition and population control in developing countries.

According to Notestein and Davis, when countries industrialized, “strong population growth initially occurred . . . because fertility remained uncontrolled and high while mortality declined, due to the improved food supplies and personal living standards.” That population growth in turn led to increased poverty and suffering, especially when it placed pressure on limited supplies of food. If, however, policy offered incentives to reduce fertility, and culture reinforced those incentives, the birth rate would fall and standards of living would rise in developing countries as they already had in Western Europe, the United States, and Canada (Szreter 2005).

Policy promoting a transition from high to low fertility was consistent with the Fund’s interests since its inception. Notestein urged policymakers to replace the premodern goal of “perpetuating the family” with the modern aim of “promoting the health, education, and material welfare of the individual child.” He told a Milbank roundtable that because individual decisions to control fertility “depend on the social setting . . . new patterns of behavior are to be established principally by the alteration of that setting” (Szreter 2005).

By the late 1950s the theory of demographic transition had been broadened into the concept of “modernization”—stages of economic development linked to changes in fertility—that for many years justified United States policy with respect to foreign aid. The final link between the Fund and transition theory occurred in 1971 when a demographer, writing in the *Milbank Quarterly*, proposed a corollary to it, the “epidemiologic transition,” which has been cited frequently by researchers and experts in policy for international development. According to this corollary, the burden of chronic disease increases as countries industrialize, as a result of longer life spans and more effective prevention and treatment of infections (Omran 1971).

During the 1950s, however, the Fund became less prominent in research and policy development based on the implications of transition theory. John D. Rockefeller III persuaded the Carnegie, Ford, and Rockefeller foundations to establish the Population Council in order to conduct research on and advocacy for family planning. Boudreau and the Fund helped to organize it. Frederick Osborn, its first president, served on the board of the Fund. Frank Notestein, who had served on the staff of

either the Fund or the Princeton Office of Population Research since 1928, succeeded Osborn as president in 1959 (Critchlow 1999).

Still, policy advocated by leaders of the Population Council and their allies in government contradicted the implications of the original version of transition theory. The research and analysis sponsored by the Fund and conducted at Princeton, Szreter writes, justified “long-term projects to promote the all-round economic growth necessary to engender the new social and cultural institutions that alone could transform traditional ways of thought.” But during and after the 1950s the Population Council and its allies focused more narrowly on disseminating information and technology for birth control (Szreter 2005). Boudreau was disappointed but, as usual, avoided confrontation (Critchlow 1999).

Boudreau’s strongest personal interest was in policy for food and nutrition. The Fund’s work in this field was quietly influential during and after World War II. At the LNHO in the 1930s, Boudreau had helped to launch a “world food movement,” aimed at “emphasizing that adequate diets were essential to human health.” The initial goal of this movement was economic recovery from the Depression. As Boudreau recalled a decade later, supplying the raw materials for adequate diets would stimulate “agriculture throughout the world [to] rise from its depression and in rising carry with it the industries needed to supply farm machinery, fertilizers, housing, roads, marketing equipment, and other essentials for agricultural rehabilitation” (Boudreau 1947).

World War II changed the priorities of the world food movement. Sir John Boyd Orr, a scientist and Nobel laureate with whom Boudreau had worked for many years, led policymaking in Britain to ensure distribution of food in ways that promoted both public health and equity. Despite food rationing and air raids, health status in Britain actually improved during the war, especially for children, in large part as a result of the policy for which Boyd Orr was responsible. In the spring and summer of 1941, Boyd Orr and Boudreau helped to persuade Churchill and Roosevelt to include freedom from want as one of the four freedoms in the Atlantic Charter (Boudreau 1947).

Boudreau helped make policy for nutrition and food supply during and after the war as chairman of the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. In December 1942, for example, representing both the National Research Council and the Fund, he discussed a “Draft Memorandum on a United Nations Program for Freedom from Want of Food” with the Peace Aims

Group of the Council on Foreign Relations (CFR). Boudreau and Boyd Orr had led the drafting of the memorandum, which recommended the creation of what subsequently became the United Nations Relief and Rehabilitation Administration (UNRRA), the International Children's Emergency Fund, and the Food and Agricultural Organization of the United Nations (FAO), of which Boyd Orr was the first director (Council on Foreign Relations 1942a).

Members of the CFR group, mainly academics, criticized Boudreau and his colleagues for proposing postwar government regulation and subsidy of the production and consumption of food in the United States and Europe. In a rare display of impatience, Boudreau replied that "politicians find it much harder to argue against a better food policy than do members of a discussion group" (Council on Foreign Relations 1942b).

Boudreau also led the Fund's participation in expanding the scope of policy with regard to mental health. According to historian Gerald Grob, for a decade beginning in the late 1940s the Fund "mobilized individuals in an effort to shift the foundations of mental health policy." The goal of this work was to accord priority to psychiatric epidemiology as a guide to the allocation of resources. Policy informed by the epidemiology of mental illness accorded priority to communities, rather than institutions, as the main sites of treatment (Grob 2004). Such policy, according to Grob, also confirmed the "psychodynamic belief that mental illness grew out of various kinds of stress and [that our understanding of it] was compatible with prevailing concepts of science" (Grob 1991).

The Fund had participated in work to destigmatize mental illness and improve treatment for it between 1915 and the mid-1920s in alliance with the National Committee for Mental Hygiene (NCMH). Clifford Beers, founder of the NCMH and a former mental patient, received part of his salary from the Fund. In collaboration with the Rockefeller Foundation, the Fund and the NCMH conducted surveys of treatment for mental diseases and devised a system of uniform statistics for reporting diagnoses. During World War I, the U.S. government used methodology devised by this project to identify and reject draftees with symptoms of mental disorder. As a result, the incidence of mental disease, including shell shock, in 1918 was a third less than it had been during fighting on the Mexican border in 1916 (Benedict 1930).

Boudreau and Samuel R. Milbank, who became president of the board in 1952, emphasized the link between the early work of the NCMH and the Fund's current activities at annual conferences devoted to mental

health research and policy. The Fund's sense of its history attracted the attention of newcomers to the field. For example, Ernest Gruenberg, a psychiatrist who later served in government in New York State and then as a staff member of the Fund, recalled that Boudreau invited him to a meeting while he was studying for a degree in public health: "I had no detailed knowledge of why the Fund was so widely respected, but I knew that public health leaders uttered the name as though it were terribly important" (Gruenberg 1990).

The Fund influenced policy for mental health through Boudreau's collaboration with Robert Felix, founding director of the National Institute of Mental Health (NIMH), authorized by Congress in the National Mental Health Act of 1946. The Fund and NIMH sponsored and disseminated studies of the epidemiology of mental illness—notably Alexander Leighton's research on the prevalence of mental illness in a community in Nova Scotia, which began in 1950 and still continues, and the Midtown Manhattan Study, landmark research on the prevalence of mental illness in an urban setting (Milbank Memorial Fund 1952; Leighton 2001).

NIMH and the Fund also encouraged and publicized advances in understanding the biology of mental illness and developing new drugs to treat it. These drugs became the therapeutic basis of policy to deinstitutionalize mental health services and create community-based mental health centers. Grob cautions, however, that "rhetoric and enthusiasm for a community-oriented program far exceeded any specific achievements." Moreover, the Fund, NIMH, and other organizations, eager to apply the results of the new science, "overlook[ed] many of the intractable problems associated with severely mentally ill persons" (Grob 1991).

A Temporary Shift in the Work of the Fund

The Fund had, however, changed the priorities and methods of almost six decades by the time the Kennedy administration, responding to the advocacy of Felix and his allies, proposed what became the Community Mental Health Act of 1963. Between 1962 and 1988 the Fund allocated most of its resources to increasing the supply of qualified faculty members in social medicine, then in health services research more generally, and then in clinical epidemiology within departments of internal medicine. Short-lived programs during these years promoted the utilization of

health services by consumers (early 1970s) and improvements in the health of farm workers (mid-1980s). Occasional grants for conferences, training, and publications addressed several of the issues of policy with which the Fund had been associated between 1905 and 1961.

Nevertheless, the Fund continued to declare that its mission was to inform policy for, and the practice of, health care and public health. For example, staff members who evaluated the Milbank Faculty Fellowships, a program initiated under Boudreau's successor, Alexander Robertson, to "prepare leadership for changes in community health for the Americas"—found that the fellows "better understand social change and how it is brought about." Moreover, some of the fellows "will reach positions where they can actively influence health policy," as a few subsequently did—for example, H. Jack Geiger, a leader in developing neighborhood health centers in the 1960s (Stensland, Levin, and Kasius 1974).

The change in the Fund's mission was evident when, in the early 1970s, it sought and received designation by the Internal Revenue Service (IRS) as a private operating foundation. Congress had created this new designation in 1969 to permit some foundations to conduct programs using their own staff, rather than working through grantees, and to offer modest tax advantages for doing so. The Fund's application to the IRS described its operations as publishing, rather than as either research or providing technical assistance to decision makers. Despite its designation as an operating foundation, however, the Fund continued to work mainly by awarding grants for higher education. For example, when he proposed the grant-funded Milbank Scholars program a few years later, a new president, Robert H. Ebert, told the board that his program would reunite epidemiology with clinical medicine in order to affect the "thinking of future generations of medical students, house officers, and practicing physicians" (Ebert 1978).

No documentary evidence reveals precisely why the Fund retreated from direct engagement with the politics of health policy. There are a few suggestions in its archives that its chief executives and many members of the board believed that, as President Leroy Burney wrote in 1973, the Fund was "too small to lay major claim to the public mind, the political agenda, or professional practice" (Burney 1973). Ebert wrote in 1977 that the "income of the Fund is limited as compared with some of the very large foundations with related interests" (Ebert 1977). At the time, Ebert was advising two other foundations with extensive programs to inform health policy: the Robert Wood Johnson Foundation, which

then had assets more than twenty times larger than the Fund's, and the Commonwealth Fund, with assets ten times larger. Nevertheless, Ebert suggested that the Fund's small endowment should be considered "a challenge rather than a constraint."

Agreeing with Ebert, the board decided in 1988 that the Fund should resume an active role in informing health policy and take advantage of its designation as a private operating foundation. The Fund would work to "influence health policy by defining . . . issues more precisely and by evaluating options more critically," as Ebert described the Fund's reinterpretation, or perhaps restoration, of its mission (Ebert 1988). In January 1990 Samuel L. (Tony) Milbank, grandson of Albert Milbank, became chairman and I became president, with responsibility for implementing the new program. In a report on the work of the Fund between May 1988 and May 1990, Ebert and I wrote that its priority was now "synthesizing the best science" in order to inform "people who make and assess policy in the public and private sectors" (Ebert and Fox 1990).

The Program of the Fund since 1990

Since 1990 the Fund has deployed its resources on behalf of persons who make and inform policy for health care and population health and who share its commitment to making practical use of the best available evidence. These constituents, decision makers and researchers, join the Fund in choosing issues of policy to address and in planning, convening, and following up on meetings to develop practical steps toward more effective policy. Most of the constituents are Americans, but the number from other countries, all over the world, has steadily increased.

The Fund's partnership with the Reforming States Group (RSG) since the early 1990s exemplifies how the Fund collaborates with constituents. The RSG is a voluntary association of senior officials of the legislative and executive branches of government from each of the states and several Canadian provinces. The RSG's Steering Committee, elected from its membership, sets annual priorities and responds to emerging issues. The Fund and the RSG convene both closed and public meetings and copublish reports directed at decision makers.

Projects with other constituents follow a similar pattern: from conversations to closed meetings, and then to public events and, often,

publications. These constituents represent, for instance, agencies of the federal government and, increasingly, of governments in other countries; international organizations; professional societies; associations of health services providers and researchers; nonprofit research organizations; and other foundations.

Constituents who are public officials frequently ask the Fund's staff for assistance with problems in making or implementing policy in their jurisdictions or organizations. Fund staff first identifies the best available evidence about a problem and persons with considerable practical experience in addressing it. Then the Fund invites these persons, who are usually constituents or accountable to constituents, to volunteer to offer technical assistance to peers. Most of this assistance is offered in conference calls and closed meetings; many of the meetings organized with constituents are public, however. Constituents also testify at public hearings in their peers' jurisdictions.

Because the Fund prioritizes prompt and thorough response to all of its constituents who request assistance, it has been involved in a broad array of issues. Here is a representative list spanning the past sixteen years:

- devising principles for reducing health spending during recessions
- reorganizing the care of persons with traumatic brain injury
- negotiating the range of benefits states can offer under the State Children's Health Program enacted by Congress in 1997
- choosing among alternative policies for regulating conversions from profit to nonprofit status by hospitals and health plans
- implementing the insurance reform provisions of the Health Insurance Portability and Accountability Act
- modifying states' policies for financing long-term care
- resolving problems caused by poorly aligned incentives for physicians to invest in information technology
- devising policy to reduce violence against women and children
- organizing a process to eliminate physical violence against federal inspectors as an unexpected consequence of the implementation of new regulations to avoid contamination in the production of meat, poultry, and eggs
- developing practicable policies for care at the end of life
- assisting adjacent states to coordinate policy and law for responding to public health emergencies

- improving the implementation of the president's Emergency Program for AIDS/HIV Relief in fifteen low-income countries
- helping the World Health Organization to test the concept of creating what its staff calls "Reforming Nations Groups," modeled on the Reforming States Group, in Africa and the Asia/Pacific regions

The Fund also brings new information to the attention of constituents. Recent examples include the Fund's work in assisting policymakers to understand and use the most advanced methods for evaluating the effectiveness of health care interventions and its efforts to document the adequacy of the retirement income that the Baby Boom generation—persons born between 1946 and 1964—can expect.

The Fund's work with its constituency since 1990 has coincided with growing acceptance of "evidence-based health care research" as a source of information for decision makers and clinicians. During the 1990s the Fund advised leaders of the Cochrane Collaboration, a new organization of scientists from more than eighty countries that conducts and disseminates systematic reviews of the effectiveness of pharmaceutical drugs and other interventions. The methodology devised by the Collaboration and other research organizations identifies biases in individual clinical studies more effectively than previous approaches to scientific synthesis. By 1999, almost two thousand systematic reviews were available to policymakers and clinicians, with hundreds more being published every year in the *Cochrane Library* and medical journals.

The Fund began that year to inform members of the RSG about the potential value of systematic reviews as guidance for policy and practice. Members of the RSG learned firsthand about the methods of evidence-based health care research in workshops led by scientists who had international reputations. By 2005, fifteen states, a large nonprofit health care purchasing organization, and the Canadian Coordinating Office of Healthcare Technology Assessment had joined in financing and commissioning systematic reviews comparing pharmaceutical drugs within therapeutic classes. Completed reviews are available on a public website (www.ohsu.edu/drugeffectiveness) and are also distributed by AARP and the Consumers Union. The Fund helped to incubate the Center for Evidence-Based Policy, the organization that coordinates this work (Fox 2005).

The Fund's work on retirement income began in 1997, when it convened policymakers and economists to discuss gaps in the information

needed to inform policy regarding the aging of the Baby Boom generation. Discussion at and following this meeting revealed that research had not addressed the question of what Americans' pensions would buy, taking into consideration the cost of living and, especially, out-of-pocket costs for health and long-term care. The Employee Benefit Research Institute (EBRI), whose president participated in the meeting, had, however, begun to collect longitudinal data about the retirement savings behavior of millions of American employees of all ages. These data could be linked to data from federal surveys of consumer spending and studies by the Social Security Administration in an econometric model designed to predict the adequacy of retirement income of men, women, and couples at different levels of income over the next thirty years.

Between 1999 and 2004, the EBRI and the Fund conducted and disseminated the results of four studies using the model: analyses of the entire populations of Kansas, Massachusetts, and Oregon, and a sample of the population of the nation. Members of the RSG led the development and implementation of the state studies. All four studies found that approximately half the persons retiring in the next three decades would not be able to pay all of their living expenses, including out-of-pocket costs for health and long-term care services. The aggregate shortfall, to be borne by government, philanthropy, and families or by greater tolerance of suffering, would be hundreds of billions of dollars (VanDerhei and Copeland 2003).

Despite coverage of these studies by leading newspapers, the debate over changes in Social Security in 2004 and 2005 displaced interest in their findings. Members of the RSG and senior business executives continue to discuss how to bring the findings of the studies to the attention of other decision makers and the public.

A noted historian of American philanthropy and public policy, David C. Hammack, assessed the recent significance of the Fund for health policy in a review of a draft of this article. The "multiplication of funding sources [for health] and the great expansion of individual rights" since the 1960s, he wrote, have made it "more difficult for governments as well as . . . private institutions . . . to devise effective and definable policies to govern their services." The Milbank Memorial Fund, he continued, "has in the past fifteen years stepped in to help senior government and private organization officials quietly find ways to deal with this much more challenging environment" (Hammack 2005).

Looking Back to Look Ahead

Imagine that Elizabeth Milbank Anderson, Albert G. and Samuel R. Milbank, John Kingsbury, and Frank Boudreau have joined the board's Committee on Evaluation for its annual assessment of the results of the Fund's program. These predecessors would probably be surprised by the enormity of the global burden of disease, in spite of economic growth and the advance of the health sciences. They would most likely be disappointed that ideology and interests still dominate the politics of health policy.

I hope that they would also recognize their contribution to the current program of the Fund. Perhaps they would be pleased that the Fund resumed their pioneering work in bringing practical knowledge to the attention of policymakers at all levels of government, in nonprofit organizations, and, on occasion, in business firms. They might take pride that the Fund, which has always had a smaller endowment than most other foundations that work both nationally and internationally, continues to have a reputation that is out of proportion to its assets.

When Albert Milbank fired John Kingsbury in 1935, he accused him of violating the Fund's "conservative tradition" (Kingsbury 1935a). For Milbank, whose views on health and social policy were in fact cautiously liberal, this phrase had special meaning. People who worked in a conservative tradition recognized that decision makers' options for action are always limited. They understood that passionate advocacy, whatever its value as political theater, often impedes difficult political negotiations about the details of policy.

The Fund's conservative tradition also requires acknowledging that opportunities for radical changes in policy are rare events in most countries, and in jurisdictions within them. Policymakers can, at best, hope to achieve incremental changes in law, regulation, and organizational arrangements that lead to modest improvements in health status and modest reductions in suffering.

John Kingsbury breached the conservative tradition he had helped to create during three decades of association with the Fund when he staked his career on the belief that the New Deal offered an opportunity for radical change in health care financing, the most controversial area of health affairs. His advocacy for this belief undercut the discipline that is a necessary basis of effective collaboration with policymakers. He demonstrated his loss of discipline by refusing to act on firsthand

evidence that Franklin Roosevelt himself had decided to limit the scope of New Deal health policy.

The officers, trustees, and staff of the Fund are stewards of an extraordinary institution. Consistent with its traditions, the Fund accords the highest priority to conserving two sets of assets: its reputation among decision makers and its endowment. These assets enable the Fund to carry out its mission of brokering practical knowledge that can lead to more effective health policy. As its chairman, Tony Milbank, told the board in October 2004, the Fund's current program is "as innovative and exciting as that designed by the founders. . . . We are an operating foundation that is wrestling with solutions to some of the most serious problems of our society" (Milbank Memorial Fund 2005b).

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Acknowledgments: The review of this article was unblinded. The author thanks eight distinguished colleagues for reviewing it with thoroughness and passion for the subject: John Farley, Bradford Gray, Gerald Grob, David Hammack, David Rosner, Darwin Stapleton, Rosemary Stevens, and Simon Szreter.