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Academic Pediatric Association (APA) Presidential Address: The Wisdom, the Will, and the Wallet: Leadership on Behalf of Kids and Families

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It has been a genuine pleasure to serve as the President of the Academic Pediatric Association (APA). The APA plays a critical leadership role in setting the agendas that shape clinical care, education, research and advocacy on behalf of kids and families. Today, I wanted to reflect on leadership lessons I have learned and relate them to the challenges we face to improve the health and wellbeing of children and families. I refer to these challenges as the Wisdom, the Will and the Wallet.

Clearly, much has changed in the last decades not only in health care delivery but also in the broader conditions that influence the health of children. Some of these changes have been good, some not so good. It is frequently said that as a profession we are too often reactive instead of proactive regarding changes in our health system. I contend that there will continue to be dramatic change and that as leaders and as an organization, we need to envision change, embrace change and push the change to make sure every child, regardless of the conditions of their birth, has the opportunity to grow up to be a healthy productive adult. We need to be proactive and prepare for the future by shaping the changes necessary to achieve our mission and improve child health and development. The APA's mission is "to improve the health of all children and adolescents through leadership in education of child health professionals, research and dissemination of knowledge, patient care, and advocacy, in partnership with patients, families and communities."¹ So today I thought we should take a moment to look into our crystal ball of the future and dream about changing the future for kids and families. What is the needed change? Do we have the wisdom, the will and the wallet to make change on behalf of children and families?

Change is certainly needed. A 2007 UNICEF Innocenti Report Card last year entitled "An Overview of Child Well-Being in Rich Countries" assessed the general welfare of children in North American and European countries of the Organization for Economic Cooperation and Development.² Our concern is the health and wellbeing of children in all countries, rich or poor, but many countries must do better for kids. The report ranked 21 countries on 6 dimensions including child and family material and subjective well being, risk, education and health and safety. It is shameful that the US and the United Kingdom ranked near the bottom with our Canadian colleagues faring somewhat better (Figure 1). Previously in this journal

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Wise and Blair plotted the UNICEF rankings of different countries against the Gini coefficient, which measures inequality in income distribution (Figure 2).³ As seen in this graph, the US has by far the greatest income equality with the UK coming in second. This inequality is highly correlated with the rankings of child wellbeing. When one adjusts for the different levels of purchasing capacity that go with a particular income level in each country, the poorest families in the US fare worse than in other countries. Also, children make up a disproportionate share of those in poverty in the US. The UNICEF report showed that compared to the other 20 countries, the U.S. had the highest relative income poverty, the percentage of children (0–17 years) in households with equivalent income less than 50% of the median (Figure 3).²

Jan Pen, a Dutch economist, created a memorable image to depict the patterns of incomes in an economy.⁴ Suppose every person in the economy marches by as in a parade arranged in order of income, lowest in front, highest in back. The heights of the people are proportional to income. You, the spectator, is of average height. In the U.S. what you would see is not steadily increasing height but something very strange. First the marchers are not seen at all as they are walking upside down with their heads underground without income but debt. Next in the parade would be tiny people. Halfway through the parade you might expect to be looking people in the eye as you might expect average height to be in the middle. But no, the marchers are still quite small. Three quarters through the parade the marchers are of average height. Then in the last minutes heights surge and moments later are 50, 100, 500 feet tall with some 933 feet depicted by the big foot. In recent years, the top end of income and skewness has greatly increased and more people are now below average.

A survey of attitudes toward income inequalities in rich countries revealed some important facts on how Americans think about inequality: 1) Americans were less aware of the extent of inequality at the top of their income distribution than were people in other countries, and 2) Attitudes toward reducing inequalities were more polarized in America than in other countries, particularly when considering reducing inequalities between the middle and lowest income levels.⁵ These attitudes may account for the relatively weak social programs in the US and relatively thin wallet in funding. Is there really a will to reduce health disparities? Aside from socioeconomic disparities, what about racial/ethnic disparities?

Although the U.S. is a very wealthy country, forty four other countries have a better record when it comes to infant mortality.⁶ Rates vary enormously by race with the mortality rate for black infants almost double that of whites in the U.S. Although there has been a decrease in infant mortality over time, the black-white gap has not narrowed. I could show many more graphs of other health indicators and other races, but I don't think we lack basic knowledge in this area. So what do we lack? The wisdom, the will or the wallet?

The Wisdom

To address health needs and disparities and improve the health of all children I postulate we need “wisdom” defined as the quality or state of being wise; knowledge of what is true or right coupled with just judgment as to action. We need not only to increase our general capacity for wisdom, but to target our wisdom on effective action. This is the scholarship to know what to do, and to teach others.

What do we know about addressing disparities? The Institutes of Medicine (IOM) report on Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care in 2003 addressed the issue.⁷ However, of the 103 studies on health disparities and meeting review criteria in the report, only 5 focused on disparities among children and few studies addressed interventions to reduce disparities. Thus this past year Dr. Renee Jenkins, now past president of the AAP, and I organized a conference to address child health disparities with the goal of establishing a research action agenda to outline the wisdom necessary to move forward. 70

multidisciplinary researcher, practitioners and funders gathered with two goals: 1) To develop a summary paper on the conceptualization of health disparities across the lifespan addressing health status, health care, and health outcomes, and 2) To develop a research action agenda to address child health disparities. We were fortunate to have many important sponsors who were participants and two panels with excellent speakers. The first panel on conceptualizing child health disparities discussed race and racism, immigrant health, genomics, and policy implications. A second panel addressed solving child health disparities from clinical interventions to quality improvement, community and economic/policy interventions.

The conference resulted in research recommendations regarding defining and conceptualizing health disparities, and the scope, content, methods and needed infrastructure for health disparities research. A fundamental problem in the field of health disparities is the lack of clear definition. If there is a call for proposals on health disparities, everyone says they are doing this research since there are differences in health status related to socioeconomic status or race/ethnicity associated with most conditions. Disparities should not be conceptualized as any difference but as an inequitable difference that is potentially systematic and avoidable. Conference participants recommended that health disparities be defined on the basis of race and ethnicity, socioeconomic status, generation, and geography as well as their complex interactions and research “should involve consideration of life chances, opportunity and risk, and quality of life in a way that includes psychosocial and socioeconomic perspectives, as well as more traditional attention to health status and the provision of health care.”⁸

Drawing from the National Research Council and IOM report “Children’s Health, the Nation’s Wealth,” domains of health should not only include health conditions, but also health functions, as well as health potential, capacity, opportunity and resilience.⁹ It is also critical to recognize that child health is increasingly dependent on social, community, and environmental factors. McGinnis studied determinants of early death in the U.S. and found that on a population basis, medical and social determinants were important including genetics, social circumstances, environmental exposures, behavior patterns and shortfalls in medical care (Figure 4).¹⁰ More important than the proportions are the categories and intersection of these influences. Health is not determined by any one of these areas in isolation but by the interconnection of all of them. Medical care and genetics are important of course, but to address disparities we must broaden the focus and find strategies to address health in the larger context.

I have only touched on the conference research recommendations. Commissioned papers and the research recommendations from the conference were recently published as a supplement to *Pediatrics*⁸ and a policy paper published in *JAMA*.¹¹ We must gather the wisdom to move the field. This wisdom must involve basic science, clinical science, community science and translational work. We need wisdom in all four areas of scholarship defined by Boyer and Glassick: 1) Scholarship of discovery: the traditional research standard; 2) Scholarship of integration: connecting discoveries from different approaches or disciplines and developing new models of care; 3) Scholarship of application: bridging theory and practice to test the feasibility and effectiveness of new models from bench to bedside to communities, and 4) Scholarship of teaching: disseminating new knowledge to students, patients, and the community.^{12–14}

The Will

Wisdom is necessary, but is not sufficient. We also need the will to create change and take bold action. The APA provides the structure and the network to assert our will and advocate for children. A central APA value is leadership. On definition of leadership is “Creating the future by initiating and sustaining change in areas where there is no precedent, as well as seizing the opportunities offered in the present.”¹⁵ I have been gratified by the success of APA’s

leadership conferences. These conferences began from the APA Division Director Special Interest Group. A survey of academic general pediatrics division directors¹⁶ identified leadership training as a need and I was happy to lead the first leadership conference in Academic General Pediatrics held in 2007 with participants nominated by Association of Medical School Pediatric Department Chairs (AMSPDC). Because of the success of the first conference, this has become an annual event with over 450 individuals participating thus far and plans underway for the fourth annual APA leadership conference.

So, what is leadership training? If one googles images on leadership it gives a sense of the skills necessary. First there are many images of tigers, lions and eagles demonstrating the leadership concepts of strength in one's mission and inspiration to act. There are images of maps, compasses, and lighthouses showing the need to set a direction and chart a path. Leadership means having a strategic plan, mission and vision, goals and objectives to take effective action on behalf of kids and families. Third there are images depicting leaders and followers with flocks of geese. Leadership clearly involves collective strength moving in one direction. Finally images of challenge and change are prominent with lightening, beach wave and mountain tops. Leadership is about embracing change, making change, and facing challenges head on. In our current environment of tremendous change, there is also tremendous opportunity and a clear need for leadership if opportunity is to be exploited.

Google images capture the 5 practices of excellent leaders studied by Kouzes and Posner including: challenge the process, inspire a shared vision, enable others to act, model the way, and encourage the heart.¹⁷ Leadership competencies include skills in strategic planning, administration and management, conflict management, finances, team building and communication skills, skills that are not a formal part of medical training despite their importance. Health profession leaders are needed today more than ever to advance child health. McKenna and Pugno have delineated four types of health professional leadership needed in healthcare today: leadership to enhance clinical effectiveness, promote organizational effectiveness, advance and disseminate evidence-based innovations, and to advocate for reform of healthcare policy, laws, and regulation.¹⁸

In the U.S. there is tremendous opportunity in ongoing efforts for health care reform. The challenge is to dispel the myth that the needs of children have been fully addressed with passage of Children's Health Insurance Program Reauthorization Act (CHIPRA). CHIPRA was an important first step in providing health care access to children. But there is much work to be done to make sure that all children and families have access to age-appropriate benefits in a medical home and quality affordable health care that meets their unique developmental health needs. We need to see ourselves as leaders and assert our will on behalf of our mission. Leadership is not a spectator sport. Finally, we have to develop our leadership pipeline which includes expanding the diversity of voices in our own leadership ranks and in the profession.

The Wallet

Along with the wisdom and the will, we need the wallet. No one has a fat wallet these days, but child health is relatively inexpensive and spending on kids offers the best possible return on investment for the future. Guaranteeing child health is an insurance policy for future health and well-being.

The "Children's Health, the Nation's Wealth" model of children's health and its influences shows the interaction of multiple influences over time and developmental stage operating in the larger ecological context of services and policy (Figure 5).¹⁹ As children age, health is reflected in a kaleidoscope. As individual pieces of colored glass are arrayed in a fixed form they create dynamic visual patterns. Influences on health change as they interact over time and throughout development. Each turn of the kaleidoscope incorporates the previous elements,

including the child's former health, and casts them in new light. All affect the child's present and future health into adulthood. This model incorporates a life course perspective that recognizes the influence of child health on adult health. There is a growing body of research demonstrating the power of child health and experience influencing adult health and chronic conditions such as cardiovascular disease, type 2 diabetes, hypertension, and mental health.^{20–22} We are beginning to learn that it is not just longitudinal influence from child to adulthood but that it goes even further spanning lifetimes and generations.

Economist and Nobel Laureate James J. Heckman has demonstrated that early investments in the well-being and skill formation of disadvantaged children pay off.^{23–25} Returns to human capital investments are greatest for the young because younger individuals have a longer time horizon over which to recoup the fruits of the investment and learning begets learning. His work shows that in the U.S. we over-invest in remedial skill programs at later ages and under-invest in the early years, increasing costs and reducing results. The Telluride Principles for Investing in Young Children, recently articulated by business, finance and policy leaders, posit that long-term US economic strength and fiscal sustainability depends on a future workforce; investing in children is a vital economic growth strategy and should be a priority.²⁶

To address inequities in health, what can we learn from some of the success stories in public health? Isaacs and Schroeder have reviewed some major public health successes over the past decades including reductions in cavities with fluoride, reductions in lead poisoning, traffic fatalities, and smoking.²⁷ They identified four ingredients of success: 1) highly credible scientific evidence that persuades policy makers and withstands attack from those whose interests are threatened; 2) Campaign advocates who are passionately committed and can withstand pressure - the Ralph Nader's, Herbert Needleman's and other crusaders as well as the backing of authoritative professional societies influential at many points in history; 3) Partnership with the media for public awareness and action; and 4) Law and regulation often at the federal level. Research, advocacy, public discussion and policy have been the critical elements in creating change and are the empirical basis for the Wisdom, the Will and the Wallet.

Finally, when I think about what has inspired me year after year at this Pediatric Academic Societies meeting and throughout the year, a big part of it has been the wisdom and will of early APA members and leaders. It is their commitment to the wellbeing of children and families that has taken APA to where we are today. With APA's 50th anniversary in 2010, we must celebrate our past successes but also keep the focus on leading the way into the future focusing on healthy children and families. As Gandhi said, "We must be the change we wish to see."

UNICEF states that "The true measure of a nation's standing is how well it attends to its children—their health and safety, their material security, their education and socialization, and their sense of being loved, valued, and included in the families and societies into which they are born."²

We must gather the wisdom, the will and the wallet on behalf of children and families for they are the leaders of our future.

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References

1. Academic Pediatric Association. [Accessed November 20, 2009]. website.
<http://www.academicpeds.org/aboutUs/index.cfm>
2. UNICEF. Innocenti Report Card 7. UNICEF Innocenti Research Centre; Florence: 2007 [Accessed November 17, 2009]. Child poverty in perspective: An overview of child well-being in rich countries.
<http://www.unicef.org/media/files/ChildPovertyReport.pdf>
3. Wise PH, Blair ME. The UNICEF report on child well-being. *Ambul Pediatr* 2007;7(4):265–6. [PubMed: 17660094]
4. Crook C. The height of inequality. *The Atlantic Monthly* September;2006 :36–37.
5. Osberg L, Smeeding T. “Fair” inequality? Attitudes toward pay differentials: the United States in comparative perspective. *Am Soc Rev* 2006;71:450–473.
6. U.S. Central Intelligence Agency. The World Factbook. Country Comparison: Infant Mortality Rate. [Accessed November 20, 2009].
<https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.html>
7. Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academy Press; 2003.
8. Cheng TL, Jenkins R. Starting early: A life-course perspective on child health disparities: developing a research action agenda. *Pediatrics* 2009;124:S161–261. [PubMed: 19861466]
9. National Research Council and Institute of Medicine. Committee on Evaluation of Children’s Health, Board on Children, Youth and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press; 2004. Children’s Health, the Nation’s Wealth: Assessing and Improving Child Health.
10. McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. *Health Affairs* 2002;21:78–93. [PubMed: 11900188]
11. Cheng TL, Jenkins RR. Health Disparities across the lifespan: where are the children? *JAMA* 2009;301:2491–92. [PubMed: 19531790]
12. Boyer, EL. Scholarship reconsidered: priorities of the professoriate. Princeton, NJ: The Carnegie Foundation for the Advancement of Teaching; 1990.
13. Glassick, CE.; Huber, MT.; Maeroff, GI. Scholarship assessed: evaluation of the professoriate. San Francisco, CA: Jossey-Bass; 1997.
14. Beattie DS. Expanding the View of Scholarship. *Acad Med* 2000;75:871–876. [PubMed: 10995606]
15. Morahan PS, Kasperbauer D, McDade SA, Aschenbrener CA, Triolo PK, Monteleone PL, Counte M, Meyer MJ. Training future leaders of academic medicine: internal programs at three academic health centers. *Acad Med* 1998;73:1159–68. [PubMed: 9834697]
16. Cheng TL, Markakis D, DeWitt TG. The status of academic general pediatrics: no longer endangered? *Pediatrics* 2007;119:e46–52. [PubMed: 17200257]
17. Kouzes, JM.; Posner, BZ. The Leadership Challenge. 3. San Francisco, CA: Jossey-Bass; 2002.
18. McKenna, MK.; Pugno, PA. Physicians as Leaders: Who, How and Why Now?. Abingdon, UK: Radcliffe Publishing; 2006. p. 66
19. National Research Council and Institute of Medicine. Committee on Evaluation of Children’s Health, Board on Children, Youth and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press; 2004. Children’s Health, the Nation’s Wealth: Assessing and Improving Child Health; p. 42
20. Gluckman PD, Hanson MA, Cooper C, Thornburg KL. Effect of In utero and early-life conditions on adult health and disease. *New Engl J Med* 2008;359:61–73. [PubMed: 18596274]
21. Kuh, D.; Ben-Shlomo, Y., editors. A Life course approach to chronic disease epidemiology. Oxford University Press; New York: 1997.
22. Halfon N, Hochstein M. Life Course Health Development: An Integrated Framework for Developing Health, Policy, and Research. *The Milbank Quarterly* 2002;80 (3):433–479. [PubMed: 12233246]
23. Heckman JJ. Skill formation and the economics of investing in disadvantaged children. *Science* 2006;312:1900–1902. [PubMed: 16809525]

24. Knudsen EI, Heckman JJ, Cameron JL, Shonkoff JP. Economic, neurobiological, and behavioral perspectives on building America's future workforce. *Proc Natl Acad Sci* 2006;103:10155–10162. [PubMed: 16801553]
25. Heckman JJ. Policies to foster human capital. *Research in Economics* 2000;54:3–56.
26. Partnership for America's Economic Success. Telluride Principles for Investing in Young Children. [Accessed January 4, 2009]. <http://www.partnershipforsuccess.org/index.php?id=37&MenuSect=2>
27. Isaacs SL, Schroeder SA. Where the public good prevailed: lessons from success stories in health. *The American Prospect* June 4;2001 :26–30.

Dimensions of child well-being	Average ranking (out of 18)	Dimension 1: Material well-being	Dimension 2: Health and safety	Dimension 3: Education and skills	Dimension 4: Family and community	Dimension 5: Services and rights	Dimension 6: Children and young people
Netherlands	4.2	15	2	4	3	3	1
Denmark	5.0	1	1	5	16	1	7
Denmark	7.2	4	4	8	9	4	12
Finland	1.6	3	3	4	10	2	11
Spain	6.0	12	6	10	8	5	2
Belgium	6.5	6	10	14	4	13	6
Norway	6.7	2	8	11	10	10	8
Italy	13.0	14	5	16	1	14	10
Ireland	16.3	18	18	7	7	4	5
Belgium	16.7	7	16	1	6	18	16
Germany	11.2	13	11	10	14	13	9
Canada	11.6	4	10	1	16	12	14
France	11.8	10	16	16	11	8	3
Japan	12.2	17	16	2	14	2	10
United Kingdom	12.8	11	15	9	18	9	14
Poland	12.9	8	7	16	12	14	16
Australia	13.7	16	14	11	2	16	14
Sweden	13.8	8	17	15	16	16	1
Portugal	14.1	17	17	15	16	16	13
United States	16.0	17	17	12	16	16	1
United Kingdom	16.2	18	11	17	16	16	16

Figure 1.
UNICEF Report Card 2007. Child poverty in perspective: An overview of child well-being in rich countries, countries in order of average rank for six dimensions of child well-being.
<http://www.unicef.org/media/files/ChildPovertyReport.pdf>

Figure 2.
Child Well-being Rankings Plotted Against the Gini Coefficient
Wise PH, Blair ME. *Ambul Pediatr* 2007;7;265-6

Figure 3. UNICEF Report Card 2007. Relative income poverty: Percentage of children (0–17 years) in households with equivalent income less than 50% of the median.
<http://www.unicef.org/media/files/ChildPovertyReport.pdf>

Figure 4.
Determinants of Health: Early Deaths
McGinnis et al, **Health Affairs** 2002;21:78-93

Figure 5.
 National Research Council and Institute of Medicine Model of Children's Health and Its Influences
 National Research Council and IOM Committee on Evaluation of Children's Health.
Children's Health, the Nation's Wealth. DC: National Academies Press, 2004.