



DISSECTING 'HUMAN CAPITAL'

*A critical look at the elements of
human capital philanthropy
through the example of The Atlantic
Philanthropies' Population
Health Program in Viet Nam*

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PREFACE

ALTHOUGH THIS REPORT DRAWS ITS EXAMPLES from The Atlantic Philanthropies' grants in Viet Nam, and many of its ideas from the experience of leaders in Viet Nam's health system, it is not principally about Viet Nam. Instead, it is an attempt to define, classify, and understand human capital philanthropy, regardless of the setting. The cases cited here are specific to one country and its particular challenges. The principles and lessons, however, are more general, intended to inform the conversation across philanthropy about the many ways foundations seek to encourage, develop, and promote human ingenuity. Admittedly, systems differ from place to place, and Viet Nam's one-party/liberalized market system is markedly different from those of other countries where philanthropy is prevalent. Still, the critical importance of cultivating talent — and of helping gifted people inform, train, inspire, and support one another — crosses most political, economic, and cultural boundaries.

Unless otherwise noted, quotations are taken from a series of interviews, conducted in Viet Nam from July 15 to 17, 2014, with physicians, educators, and policymakers who have been grantees of Atlantic's Population Health Program. Quotations from Dr. Le Nhan Phuong, Atlantic's Country Director in Viet Nam through 2013, are taken from a series of interviews with him between 2012 and 2014. Dr. Phuong made all of the logistics for this report possible, inspired most of the questions it seeks to answer, and is the source of many of its best insights. He reviewed an early draft and made several helpful suggestions, as did Atlantic's Chief Communications Officer, David Morse, and two members of Duke University's Center for Strategic Philanthropy and Civil Society: Director Joel L. Fleishman and Program Coordinator Mary Grimm. (Professor Fleishman was president of Atlantic Philanthropic Services, the foundation's U.S. grantmaking arm, from 1993-2003.) Their efforts significantly improved the clarity of the final report. For all the rest, including any errors of fact or judgment, the author bears sole responsibility. ■

SUMMARY

INVESTING IN EXCEPTIONAL LEADERS is a fundamental element of all good grantmaking, whatever its purpose. As Chuck Feeney, founder of The Atlantic Philanthropies, put it: “It all starts with good people.” Yet sometimes, supporting “great people” can be not only a start, but a worthy end in itself.

Some grantmaking, known in some circles as “human capital” philanthropy, aims principally to cultivate outstanding people. This is most obvious in the case of fellowships and prizes, training programs, paid sabbaticals, and the like, whose focus is on giving great minds the means and latitude to flourish. But other variations on this approach have a more focused intent: building a field or advancing a cause by fueling the talents of those most likely to lead the charge.

Atlantic’s experience in Viet Nam provides a case in point. There, over a span of 15 years, Mr. Feeney and his Foundation invested in a wide-reaching reform of the country’s public health and primary health care systems, particularly in poor, remote, and underserved communities where the great majority of the population lives. It was a program explicitly built around the support of outstanding reformers, innovators, and leaders. Christopher G. Oechsli, an early architect of the Viet Nam work and now Atlantic’s president and CEO, describes the effort as “human capital with a purpose.” Its aim was to help modernize the public and primary health systems in Viet Nam. But to do that, it set out first and foremost to fill a leadership gap — that is, to find, train, equip, and extend the influence of the country’s brightest and most driven leaders and innovators.

The result, apart from sweeping improvements in the health and health care of millions of disadvantaged residents of Viet Nam, has been a case study in purpose-driven human capital philanthropy. The following pages examine that story, with examples drawn from the experience of several rising stars whom Atlantic has supported, or with whom it has collaborated, over the years. The program suggests several broad principles that could guide any similar human capital effort, in any field or country.

“It all starts with good people.”
— Chuck Feeney

FIRST, HUMAN CAPITAL INVESTMENTS of this kind take five main forms, though the strongest efforts combine two or more of these into a single initiative. They are:

- **DIRECT EDUCATION AND TRAINING OF INDIVIDUALS** — whether narrowly focused on individual leaders or widely aimed at practitioners across a field.
- **SUPPORT FOR EDUCATIONAL OR TRAINING INSTITUTIONS** that carry out such training.
- **SUPPORT FOR LEADING EDUCATORS** committed to raising skills and standards of practice.
- **NETWORKING** among leaders, educators, and reformers focused on common goals.
- **SUPPORT FOR PROJECTS OR INSTITUTIONS** that can serve as platforms for demonstrating and promoting a leader's vision.

In circumstances where fields are still young, vaguely defined, poorly understood, or under-populated, it may not be enough simply to support a few star players and hope that a system will form around them. Instead, it may be necessary to organize more widespread programs of training and mentoring all across a field's ranks of frontline practitioners. Yet even then, achieving that goal often depends on helping a few outstanding figures gain the means and stature to propel the broader effort. In short, even massive skills-building projects often start with the cultivation of individual talent.

Connecting emerging leaders with one another is a further way to multiply and accelerate the benefits of investing in human talent. Forging networks of the most gifted and influential people pays a double dividend: It can both deepen their individual expertise through peer-to-peer learning and extend their influence through coordinated action. In less-developed places, donors can raise a leader's chances of success by helping to forge relationships with experienced people from more-developed countries, to help leaders implement their plans, build confidence, exchange ideas, and accelerate the transfer of knowledge.

Effective leadership development rarely comes from a single donor's intervention alone. The most effective approach usually combines grants to individuals, which might come from a single foundation or program, with more multifaceted efforts to build momentum for their innovations — drawing financial and political support from policymakers, prominent academics, opinion leaders, or some combination.

BUT A SINGLE DONOR can set a wider effort in motion by spotlighting promising people with far-reaching ambitions and helping them demonstrate and evaluate their ideas. They can do this by, among other things, supplying the facilities, equipment, and technology they may need to get started. Sometimes, creating high-profile buildings, like laboratories, offices, or classrooms, can by itself boost the profile of the ideas and the leaders they house, by creating an environment that attracts other gifted people and that draws wider attention. The backing of an independent donor with extensive, perhaps international, connections can also lend legitimacy to an emerging leader's work and attract further local attention and support.

Helping visionaries *sell* their vision — linking them to strong advocates, introducing them to other influential people, and providing them the means to cultivate their own persuasive skills — is another way that funders can amplify and multiply an outstanding person's influence. Often, support for an idea is only half the equation; the other half is drawing attention, building a case, and then driving the message home through media, professional networks, and public-policy channels. Support for evaluations, data-gathering, and outcome tracking may further bolster an innovator's influence, effectively turning evidence into outcomes.

There is no clear, bright boundary that distinguishes human capital philanthropy from other kinds of smart grantmaking. Returning to Chuck Feeney's insight, it *all* starts with good people. Even when the main goal isn't cultivating talent — when the real purpose is to find better treatments for a disease or improve curricula in schools or reduce inequities in the economy, or some other purely objective aim — most efforts depend on the leadership and guidance of extraordinary people. But in some fields, the *primary* obstacle to progress is a talent gap: a shortage of creativity, skill, and advocacy, or a blocked path to leadership for the most creative and talented people. When that is the case, promoting a cadre of gifted people can have a multiplier effect, leading to the attraction and nurturing of even more talent.

A human *capital* program is designed to produce a flow of returns in the form of more and more people with skills coming into the field and excelling. Arming prominent figures who inspire, mentor, and attract others is a means of *leveraging* talent, not merely rewarding it. It invests in a few people who, if wisely chosen, will in turn cultivate many.

DISSECTING HUMAN CAPITAL

“The acquisition of ... talents, by the maintenance of the acquirer during his education, study, or apprenticeship, always costs a real expense, which is a capital fixed and realized, as it were, in his person. Those talents, as they make a part of his fortune, so do they likewise that of the society to which he belongs.”

— Adam Smith, *The Wealth of Nations*, 1776ⁱ



PART 1: THE FIVE
COMPONENTS OF HUMAN
CAPITAL PHILANTHROPY

MITCHELL SVIRIDOFF, a pioneer of social-change philanthropy as vice-president of the Ford Foundation in the 1960s and '70s, once told a group of Ford program officers and junior staff: "All successful grants are investments in people. So are some unsuccessful ones — not everyone lives up to expectations. But every success depends on someone who has an idea, gets it done, and turns it into something bigger than one project. Back that person, and you've got a chance of making a difference. ... Good ideas don't necessarily make good grants. Good people do."ⁱⁱ It is a philosophy that closely matches the personal, entrepreneurial grantmaking of Chuck Feeney, founder of The Atlantic Philanthropies.

Mr. Sviridoff worked mostly before the phrase "human capital" had made its way into the vocabulary of modern philanthropy. In the remarks just quoted, he was not focusing only on what has become the standard arsenal of today's human capital grantmaking — which mostly includes scholarships, fellowships and prizes, training programs, paid sabbaticals, grants for research and writing, and the creation of "leadership vehicles" like think tanks and innovation shops, from which gifted people can exert influence. In fact, Mr. Sviridoff's remarks were not about any particular branch of philanthropy at all. They were about *all* philanthropy, or at least all philanthropy that worked.

Consequently, to the extent that major grantmakers like Chuck Feeney and Atlantic still take the overall approach that Mr. Sviridoff endorsed in the 1970s, it can be hard to pinpoint, among their efforts, a clear subset of projects specifically devoted to "human capital." If most grants are at least partly a bet on some prospective leader or group of leaders, or on the skills of a field's leading practitioners, how do you isolate the ones that are *primarily* designed to support such people, and that are specifically aimed at cultivating their talents, encouraging their ambitions, and helping them widen their influence? If all great endeavors depend on great leaders, is it possible to describe a logical boundary between investments in leadership *per se* and investments in the things that leaders can accomplish? And if it is, are there useful things to learn from the distinction?





ATLANTIC'S 15 YEARS OF SUPPORT for Population Health in Viet Nam, which largely concluded in 2013, provide a body of experience from which to start answering those questions. Much of this work was an outgrowth of Chuck Feeney's personal grantmaking in the early years, and as a result, it continued to reflect his emphasis on finding and backing gifted, energetic, and visionary people. A critical element of Atlantic's strategy in Viet Nam, as described by then-Country Director Le Nhan Phuong, was "finding leaders who had a vision for what needed to be done, and helping them with whatever they needed to realize that vision — whether it was networking with experts in other countries, or training or education, or just money to start implementing their ideas. Obviously, we had to believe in the vision and that it would work." But that confidence would be much stronger — and a way forward would be much more clear and navigable — if there were one or more outstanding, ambitious people ready to lead the charge.

Sometimes, the leader's vision included, in turn, a further and wider attempt to develop human capital — for example, a push to train hundreds of new public health professionals in a country where public health had been a little-recognized niche occupation until the early 2000s, or a widening attempt to elevate staff training in primary health care and family medicine for the staff of Viet Nam's community clinics. These mass-training initiatives represented the most basic (though often exceptionally difficult) model of human capital philanthropy: direct expenditures to provide education and credentials. Yet even in these cases, Atlantic's starting point usually was not the training regimen itself, but first, the formation of working alliances with people who would be most likely to lead, expand, and sustain it. So, first would come a relationship with outstanding educators, reformist public officials, or determined leaders of health care or nonprofit organizations — even when (perhaps especially when) their ambitions were still outside the mainstream. Next might come an investment in strengthening the institutions or programs that they lead. Finally, with those visionaries and institutions in the vanguard, Atlantic could more confidently support a broad-based training or education project.

IN OTHER CASES, broad training and other traditional forms of human capital development were not the focal point of the relationship at all. Instead, the goal was to boost the skills, stature, and track record of the strongest proponents of change, and thus, by equipping them to succeed, fueling the changes they sought to promote. So several signature Atlantic projects began with the recognition of exceptional talent and leadership in the head of a hospital or university, a mid-level government official, or someone in a nongovernmental organization. With these promising figures in the lead, Atlantic could make grants for new facilities to serve as physical platforms for the leaders' visions. It could invest in programs that would operate under their direction, expanded research and advocacy to boost the credibility of their work, and collateral support for replicating their successes elsewhere. Or it might provide them with opportunities for advanced education and training, advice or consultation from Atlantic grantees in other countries, or networking opportunities at international conferences and symposia (and in later years, increasingly online). In time, some of these leading figures moved into positions of even greater official authority, thus both validating their work and providing a higher platform from which to promote it.

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WITHIN EACH OF THESE EXAMPLES, several kinds of support for human capital are usually woven together. But it is possible to unravel them and examine the component approaches to supporting talent, skills, and expertise. In much of Atlantic’s philanthropy in Viet Nam, there have been five fundamental kinds of human capital grantmaking in play, of which more than one may have been combined in any given initiative:

 <p>DIRECT EDUCATION AND TRAINING OF INDIVIDUALS – for example, tuition assistance for professional or postgraduate study, or free training for clinic workers.</p>	 <p>NETWORKING OPPORTUNITIES, or “learning communities” for leaders, educators, or reformers to connect with one another and with experts from other disciplines and countries — including Atlantic’s support for affinity groups like Viet Nam’s Public Health Association, National Family Medicine Association, and National Institute of Ophthalmology; for international and regional conferences; and for grantee-to-grantee mentoring and consultation among experts from different countries.</p>
 <p>SUPPORT FOR EDUCATIONAL INSTITUTIONS OR PROGRAMS that train professionals, such as Atlantic’s stream of grants to the Ha Noi School of Public Health and to medical universities around the country.</p>	 <p>SUPPORT FOR DEMONSTRATION PROJECTS LED BY VISIONARY AND AMBITIOUS LEADERS, which help them implement and prove their ideas — for example, reform initiatives by officials in provincial and national health policy, who not only carried out superior models of service delivery with Atlantic’s support and promoted them up the policy hierarchy, but then sometimes rose in the ranks themselves, acquiring wider and wider circles of influence.</p>
 <p>SUPPORT FOR EDUCATORS COMMITTED TO RAISING SKILLS AND STANDARDS OF PRACTICE – including opportunities for professors and university officials to pursue advanced study, and grants to help them improve the way their colleagues, subordinates, and students are trained.</p>	

IN A SERIES OF INTERVIEWS in July 2014, Vietnamese public officials and educators commented on these strands of work and offered personal reflections and examples from their own experiences as frontline partners of Atlantic, beneficiaries of its approach to human capital, or both. Their thoughts and experiences, detailed in the next section, provide a basis on which to examine each of the five essential forms of human capital grantmaking and to consider how they relate to Atlantic’s broader interest in promoting leadership in health equity, not only in Viet Nam but internationally. By implication, they also shed light on the techniques of human capital grantmaking that are applicable to almost any field of philanthropy. ■



PART 2:
THE FIVE COMPONENTS
IN PRACTICE



DIRECT EDUCATION AND TRAINING

IN MANY BRANCHES of Atlantic's work in Viet Nam, the challenge was not merely to improve some category of health service or education, but to nurture whole fields that were still embryonic or were stuck at a rudimentary stage of development. An example of an embryonic field was public health, which was not even a recognized professional discipline in Viet Nam when Chuck Feeney began making grants there in 1998. To help expand and populate the field, Atlantic invested roughly \$11 million in the Ha Noi School of Public Health between 2001 and 2012, not just to fortify its curriculum, provide new equipment, and plan for rapid growth, but also to subsidize advanced learning for key faculty members interested in studying abroad. They would, in turn, bring back to the School a fresh international perspective and new approaches to teaching and mentoring. There will be more to say about the consequences of this approach, for both the School and its field, under a later heading.

An example of an established but underdeveloped field was primary health care — the most basic and widely applicable form of medical practice, covering all the routine health needs of most families. Across much of Viet Nam, especially in poor and remote areas, the source of primary care was the commune health center, a local clinic serving, on average, around 10,000 people, in facilities that were too often dilapidated, under-equipped, under-supplied, and thinly staffed by minimally trained personnel with low morale. In Viet Nam, where physicians enter professional practice with a six-year undergraduate medical degree, most doctors in commune health centers were in effect employed as family practitioners lacking many of the most basic tools, and with no specific training in family medicine — in fact, in the great majority of cases, with no post-baccalaureate training at all.

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BY 2001, some Vietnamese medical schools were beginning to offer graduate-level family medicine programs, but according to a later review of Atlantic's work in Viet Nam, "all the curricula shared a focus on training family medicine doctors for big hospitals and urban environments." ⁱⁱⁱ Graduates of these programs overwhelmingly chose to stay in the major cities where they trained. The Western form of intensive medical residency they experienced there was beyond the reach of employees in most commune health centers, who had neither the time nor the means to pursue years of training in faraway capitals. Some senior health policymakers believed that training them would be pointless anyway, because afterward, most would flee the dilapidated clinics and take their new credentials to more upmarket places. Nonetheless, the national Ministry of Health in 2003 adopted a policy that called for family-medicine training for all primary health care nationwide. Unfortunately, it had no realistic plan for how this would work in the commune health centers — a problem widely acknowledged even among Ministry officials.

So the challenge, for Viet Nam and for Atlantic, was how to offer low-income and rural Vietnamese families — the great majority of the population — a form of family medicine and a level of primary and preventive care that met their actual needs close to home. This would require developing whole cadres of professionals province by province, given that the provinces control most health resources. It was a mission far beyond any foundation's ability to pay for on its own. Instead, a donor would need to support institutions and leaders in provincial and district government who could design effective training programs, implement and refine them, ensure they were meeting the most pressing needs, and then — critically — win the support of higher-level health executives who could allocate money to expand them and make them permanent.

The core of this whole challenge was cultivating people, both at the top and the bottom of the hierarchy. Accordingly, a Foundation report concluded in 2013, "the *entire Population Health program* in Viet Nam is designed around the kernel of human resources development." ^{iv} To multiply the frontline human resources dedicated to primary care and public health, Atlantic would focus on the higher-level personnel in education and public policy, who would in turn train, inspire, deploy, and equip battalions of new practitioners.

Enlisting allies in government and partners from Australia and the United States, Atlantic devoted \$5.5 million to creating a fundamentally new way of training practitioners in community clinics, equipping them with the professional armature of family medicine, but without transporting them to distant cities for years of specialized education. Concentrating on Viet Nam's less-developed Central Region, and starting with the Hue University of Medicine and Pharmacy, the new program trained physicians in basic techniques from various components of family practice, such as perinatal care, reproductive health and family planning, pediatrics, cardiovascular health, and mental health.

ADVISORS FROM Boston University’s Family Medicine Global Health Cooperative trained members of the Hue medical faculty to teach and mentor field personnel in the new regimen. Complementary training was tailored for nurses and pharmacists who also practice in the clinics. And all of this was aimed at practitioners who were already working in — and often grew up in — disadvantaged communities. Instead of training them to look elsewhere for advancement, it offered them a kind of advancement-in-place, where their skills, their effectiveness, and their prestige could all be elevated without having to leave home.

But what would keep them dedicated to their clinics once they had superior training in skills that would be marketable elsewhere? For that, it would also be necessary to upgrade the facilities, provide them with essential equipment and supplies, and improve their connections, both technological and political, to higher ranks of the health care system. “To improve the quality of primary care in Viet Nam,” says Nguyen Minh Tam, director of the Family Medicine program at Hue University of Medicine and Pharmacy, “we have three cornerstones: We need to have good leadership and a commitment to support primary care. We need to improve the infrastructure and equipment for primary care at the commune health centers. And we need to improve the capacity of the staff.” Atlantic, with its Vietnamese and international partners, set out to invest in all three. The model started in one province, Khanh Hoa, soon expanded to Da Nang and then Thua Thien Hue, and later to other provinces, regions, and medical schools.

It was the visionary director of the Khanh Hoa Health Department, Dr. Truong Tan Minh, who initially formulated the three-cornered approach, in a series of discussions with Atlantic’s then-Country Director, Dr. Phuong. As an Atlantic staff memo described it in 2003, “Dr. Minh’s goal is to turn Khanh Hoa into the national model for how to reform the health care system and how to make it accessible to all of its inhabitants.”^v He began working with Atlantic on a plan for modernizing the clinics’ buildings and equipment at about the same time that Atlantic and Boston University were helping Hue Medical School create the new family medicine program in which the clinics’ staff would be trained. As the facilities were being renovated or rebuilt, Atlantic also began subsidizing the tuition of practitioners who enrolled in the new program.

<p>“WE NEED TO...</p>	<p>Improve the infrastructure and equipment for primary care at the commune health centers.</p>	<p>Improve the capacity of the staff.”</p>
<p>Have good leadership and a commitment to support primary care.</p>		<p>—NGUYEN MINH TAM</p>

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THE THREE-CORNERED STRATEGY has worked. With just over one-third of the doctors in Khanh Hoa's primary care clinics now trained in family medicine, not a single graduate has left the province. One doctor moved from his commune health center to work in a program elsewhere in the province dedicated to HIV treatment. But all the rest are still working in the same (albeit rebuilt or renovated) clinics from which they enrolled in the family medicine program. Leadership in health policy, all the way up the hierarchy, has become substantially more supportive of Dr. Minh's model, which is now being expanded without further investment from Atlantic. The Hue family-medicine faculty has grown and has established the new curriculum as an established branch of postgraduate medical education. And the widening improvements in commune health centers have made it more feasible to practice higher-quality family medicine at the community level, as well as more appealing for doctors to continue working there. After closely observing this demonstration, in 2013 the World Bank launched a \$121 million project, including contributions from the European Union and the Vietnamese government, to make family medicine "the backbone of the primary healthcare system in Viet Nam." ^{vi}

It is important to note that although the goal was to provide direct education to frontline health workers, the first human capital challenges were actually not at the front lines, but farther up the hierarchy. The first, and most essential, human asset was Dr. Minh himself, in whom Atlantic was investing substantially by helping him realize his three-cornered vision in a dramatic, but carefully coordinated, sequence of initiatives underwritten jointly by the Foundation and the province. Until his ideas were demonstrated in actual renovated buildings, with well-trained staff who stayed at their clinics, he would not have gotten far persuading his provincial government (much less the national Health Ministry) to fund the full scope of his vision.

In the drive to improve training for clinic personnel, Atlantic's next level of investment was in the Hue medical faculty, which had never had a family medicine curriculum. Professors in the newly formed department had to master an entirely new model of family-practice education that combined classroom and field training for overworked physicians in commune health centers. Only then, after supporting the leadership and the pedagogy, and while also supporting new construction and equipment at the clinics, was Atlantic able to move to the ultimate target of its human capital strategy for primary health care: the primary care providers themselves.

In short, what would appear to be the simplest and most obvious form of human capital grantmaking — educating more professionals — was actually intimately bound up with, and dependent on, several other forms of investment in people. All of these had to be integrated with one another, often involving multiple partners with different kinds of resources and expertise. The next sections look more closely at these other elements of human capital investing, both as individual strategies and as components of a broader and more complex undertaking. ■



SUPPORT FOR EDUCATIONAL INSTITUTIONS AND PROGRAMS

ATLANTIC'S INVESTMENT in the faculty of Hue University of Medicine and Pharmacy began with an early investment in Dr. Tam, who later became its first director of family medicine. Well before he took that position, he had won a scholarship in 2004 from a program instituted by Chuck Feeney at the University of Queensland, where he pursued his Master's degree in public health. Although Atlantic did not select him (the choice of students was up to the university), the purpose of the scholarship program was to zero in on likely leaders, and Dr. Tam clearly fit that criterion.

Returning to Hue, he rose to become vice-director of the medical school's Public Health Program, working in a new building funded by Atlantic. In 2007 he won another Atlantic-sponsored fellowship, this time at Queensland University of Technology, with which he earned his Ph.D. in public health. His training in both medicine and public health — together with a professional and intellectual interest in the health of poor and rural communities — made him the logical choice to lead the new Family Medicine Department.

Atlantic's support for Dr. Tam's department helped with more than just assembling a faculty and drawing up a curriculum. It was aimed at a more difficult proposition: designing a form of teaching and learning that would suit a demoralized group of practitioners struggling, in rundown facilities, to serve needy people leading hard lives. This was not a program that could borrow some textbooks from Queensland or Boston and simply translate them into Vietnamese. "Good practices are everywhere," Dr. Tam says. "But if you learn them from developed countries, you have to know how to adapt them, revise them, and apply them back to Viet Nam. That is a learning process we had the opportunity to pursue, thanks to Atlantic."



BESIDES HELPING TO FUND the Public Health building at Hue University of Medicine and Pharmacy, Atlantic invested some \$3 million in the partnership between Boston University and Hue's Family Medicine department. Working together, professors from Boston and Hue refined the curriculum, developed the young faculty into masters of the new training approach, and more recently produced a textbook tailored for this curriculum and its students.

The textbook exercise, like much of the school's approach to family medicine, has required a kind of cross-disciplinary teamwork not typical of Vietnamese medical schools in the past. Dr. Tam says he initially found it a challenge to work closely with a wide circle of colleagues in many specialties. But it became a cornerstone of his program: "I invite older professors, leaders from internal medicine, obstetrics/gynecology, pediatrics — all the leaders and experts in those areas [to] come together and discuss how to teach family medicine. At the beginning, the family medicine program was just the adding-up of [separate specialties]. Each department would teach — but not much — its own part of family medicine. ... Now they talk together and come up with solutions."

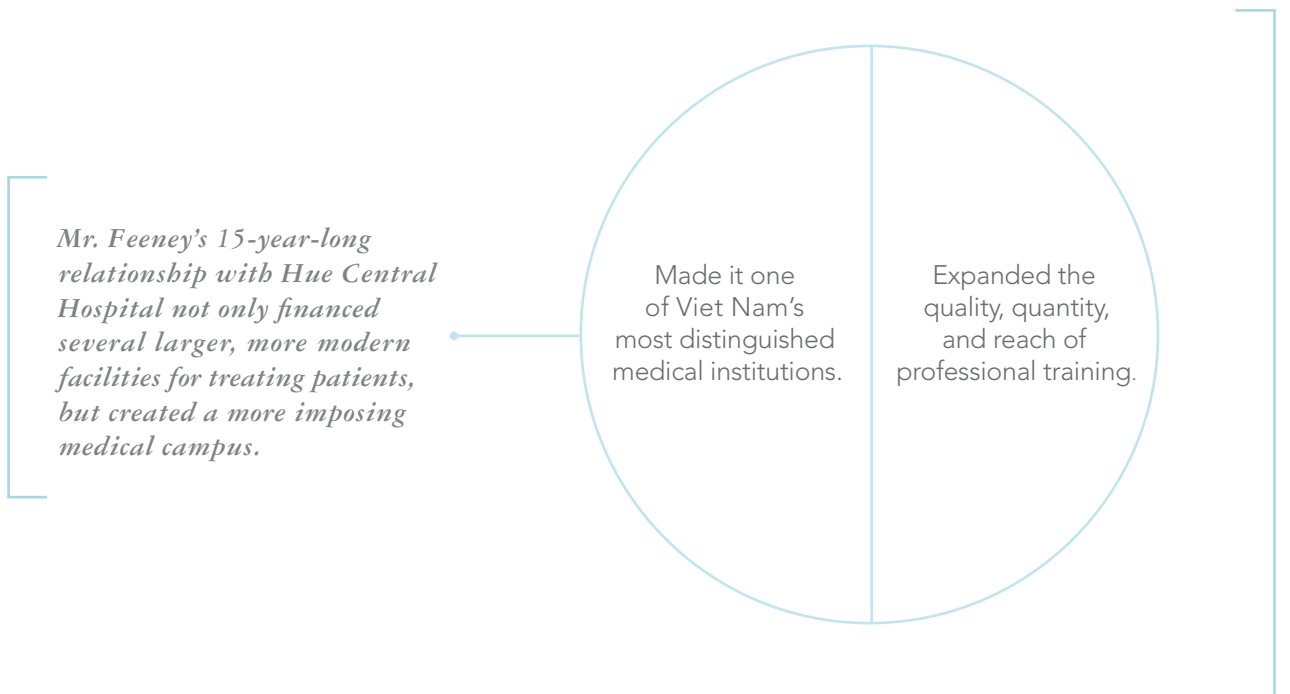
One advantage of having the backing of Atlantic, both for the school in general and for Dr. Tam's leadership in particular, is that an international donor, and outside experts like those from Boston and Queensland, can attract the attention and cooperation of people who might otherwise have felt no incentive toward teamwork. "I can bring the Buddha in from outside," as Dr. Tam puts it, "to get people's attention and to encourage collaboration."

A critical part of Atlantic's approach to supporting education and training is the upgrading of facilities in which such training takes place, including not only universities but teaching hospitals and training centers. As part of the training program for family practitioners in Khanh Hoa province, for example, Atlantic supported the creation of a new Family Medicine Training Center in the province, so that faculty from Hue and Boston universities could hold classes close to where their physician-students practice, thus reducing their need to travel the longer distance to Hue.

In public health, a field strategically allied with family medicine, Atlantic's effort to build human capital has likewise included the creation of new facilities.^{vii} Although its support for the flagship Ha Noi School of Public Health did not involve new construction, Atlantic provided state-of-the-art equipment and played a key role in helping the School negotiate a relocation to a brand-new campus, a project that is nearing construction as this is written. Atlantic directly financed new facilities for the Public Health Faculty at Hue University of Medicine and Pharmacy, and has supported technology and equipment upgrades at several other schools and departments.

THE PURPOSE OF THESE CAPITAL IMPROVEMENTS has been greater than just creating more space to train more people. Just as critically, the new facilities have helped to raise the visible stature of new fields and institutions that are not yet well established in Viet Nam’s educational and professional hierarchy. This use of buildings and infrastructure to boost an institution’s profile is a tactic taken directly from Chuck Feeney’s approach to philanthropy. From his earliest grants for education and medicine, in virtually every country where he worked and every institution he supported, part of his aim was to enrich the look and feel of underappreciated places and enterprises, to make them more attractive, inspiring, and impressive — to “make a campus more complete and more competitive,” as a senior Atlantic executive put it in 2010.^{viii}

Thus Mr. Feeney’s 15-year-long relationship with Hue Central Hospital not only financed several larger, more modern facilities for treating patients, but created a more imposing medical campus. The boost in both capacity and prestige has included significant medical milestones reached at the hospital and made it one of Viet Nam’s most distinguished medical institutions. More to the point, it has greatly expanded the quality, quantity, and reach of professional training. “Here, we are not only treating patients,” Dr. Bui Duc Phu, the hospital’s director, wrote in a 2014 tribute to Mr. Feeney, “but also training health personnel — physicians, nurses, and aides — who later provide services throughout the country. ... We have trained a generation of experts who can then train future generations, not only for Hue Central Hospital, but for other regions of the country.”^{ix} ■





SUPPORT FOR EDUCATORS

AMONG ATLANTIC'S INVESTMENTS in the Ha Noi School of Public Health was another example of a classic Chuck Feeney tactic: transferring human capital from one place to another by forging partnerships among grantees in multiple countries. In this case, the Foundation tapped Queensland University of Technology (QUT) to help the Ha Noi School with business planning, curriculum development, and advanced-degree fellowships for faculty members to study in Australia. Part of the theory behind these fellowships was that by helping the best professors deepen their credentials and widen their international horizons, Atlantic could pursue two critical, intertwining goals at once: enriching the quality of teaching at the School, and boosting its prestige and visibility in the eyes of Viet Nam's highly credential-conscious government.



One of the junior faculty members chosen for a doctoral fellowship at QUT, Nguyen Thanh Huong, later rose to become the School's vice-dean for research and education. She is now responsible for the quality of pedagogy at the School, and thus for the way future graduates of the country's most elite public-health university will be trained, and eventually, the way they will approach their work. But 15 years ago, her journey to that position seemed improbable at best.

With a Master's degree in pharmaceutical chemistry, Professor Huong was a promising lecturer at the highly regarded Ha Noi School of Pharmacy, one of only two Vietnamese pharmaceutical universities. Because her research concerned the use of antibiotics, she developed a growing interest in public health — a barely recognized field that was then nearly impossible to study at an advanced level in Viet Nam. She won a government scholarship to pursue a Master in Public Health degree in Australia, which she completed in 1997. "And then," she says, "I made a big decision."

SHE REQUESTED A TRANSFER to join Ha Noi's only public health faculty, a tiny team lodged at what was then called the Ha Noi School of Health Management. Though it would eventually be transformed into the Ha Noi School of Public Health, the school was then not even recognized as a university. It mainly offered short-term training for public officials taking on new responsibilities in the country's health system.

"Frankly, many people asked me why I would leave the pharmaceutical school, because I had good potential there," she recalls. Not only was she headed for a promotion in her current position, but "in terms of university status, the Pharmaceutical School was much higher." With a future before her that many academics would envy, and armed with a newly minted Master's degree and greatly improved facility in English, she was about to take what most of her colleagues considered a giant step downward.

But to Professor Huong, the opportunity she wanted to pursue was less a career than a calling. "I just wanted to do something in public health," she says. At the School of Pharmacy, that hope would never amount to anything more than a sideline. At least at the lower-status Health Management School, she would have a few like-minded colleagues and could concentrate on her field. "If I wanted to practice public health," she concluded, "it would be better to move. That was my thinking — I was not counting on how much money I would earn or what kind of further scholarships I could get, not at that time. Just practicing public health. And becoming vice-dean? It was never in my mind."

She requested the transfer in 1999, the year her new institution granted its first Master's degree. So peculiar did her choice seem to her superiors that it took her more than a year to win their approval for the move. When she joined the public health faculty in 2000, her new employer was still a year away from being designated a university. But roughly a year later, Atlantic would begin a stream of grants to support the School's growth, including the opportunity for doctoral study abroad. Among the earliest applicants for one of those doctoral fellowships was Professor Huong, though at that point she had barely heard of Atlantic. She returned to Australia in 2004 and, three years later, with her Ph.D. completed, resumed full-time teaching.

In early 2012, the dean asked Professor Huong to become vice-dean for research, a position she spent months trying to resist. "I didn't want to be in a management role," she explains. "The dean asked me several times, and I refused. ... Frankly, it was never my aim to become a manager, be the boss. I'm more interested in improving the public health profession than in managing." Eventually the dean prevailed, promising that the new job would not mean the end of teaching and mentoring graduate students. "I could still do both," Professor Huong reckoned, "but my life would be a lot harder." It was about to become harder still: A year later, she was made vice-dean for both research and education.

IN THE EDUCATION ROLE, Professor Huong has greatly expanded the school's emphasis on in-service training, encouraging degree candidates to devote part of their learning time to solving public health problems they actually confront in their communities. By encouraging Master's and doctoral degree candidates to write theses on real-world problems, Professor Huong and her colleagues are departing from traditional university practice in Viet Nam. But that, in her view, is part of the point. "It makes the students' education more useful, more practical, not just academic. And their education is immediately put into practice back at the office, because [during their studies] they've worked on problems they actually need to solve. So you're not only educating the students, you're contributing directly to the practice of public health in their communities."

More fundamentally, and in the longer run, Professor Huong hopes to unsettle some of the most fundamental aspects of the way students learn in Vietnamese classrooms. Too often, she believes, students are trained to be deferential and reserved, unwilling to challenge assumptions or ask probing questions, and disinclined to stand out from their classmates in any way. They "learn to be passive people," she says, "just listening and learning by rote. Even the top, smartest students."

During her years studying in Australia, Professor Huong experienced a different kind of education, demanding more assertiveness, independence, and critical interaction with classmates and professors. This she now struggles to instill at the Ha Noi School of Public Health. A more spirited approach to professional education, she believes, is especially critical in a new field like public health in Viet Nam, where "sometimes you just have 30 seconds or one meeting to explain what you're doing, to people who have no idea what public health is. ... It's a young field that needs promotion. But if you're shy and dependent and reserved, you're not going to advance the field." In just under two years as vice-dean, Professor Huong feels the school has made "a little" progress and is determined to bring about more.

Through its long relationship with Professor Huong and the Ha Noi School, Atlantic has not merely helped a visionary educator rise in the ranks — which may have happened anyway — but it has helped widen her horizons and supported her attempt to enrich the way the next generation of professionals masters the disciplines of public health. Not only have enrollment, the number of degrees conferred, and the quality of instruction all risen sharply in these years — improvements that Professor Huong credits in significant part to Atlantic's intervention, as well as to earlier support from the Rockefeller Foundation — but the School's influence has spread far beyond its walls.

THE HA NOI SCHOOL has been tapped to support public health faculties at major universities in other parts of the country where Atlantic has also made major grants for both facilities and leadership. Also, as this is being written, Professor Huong and her colleagues are consulting directly with human resources officials in the national Ministry of Health to define the essential competencies required to be recognized as a public health professional in Viet Nam, similar to those already established for physicians, nurses, and pharmacists. Among Professor Huong's ambitions for the next few years is to expand the School of Public Health Without Walls, where each year, 50 to 60 researchers and frontline practitioners from all over the country study public health while spending roughly half their study time in the field.

There most likely would have been a field of public health in Viet Nam with or without Atlantic. It no doubt would have grown beyond its minimal scope and stature, one way or another. But Professor Huong and others believe that it would not have grown as quickly, attracted as many practitioners, reached its current level of professional sophistication, or achieved anywhere near its current status in national health policy without the Foundation's deliberate investment in the people and institutions responsible for training and populating the field. A critical part of that investment has been Atlantic's effort to give the most dedicated and ambitious educators the opportunity to build their expertise, not solely in public health, but in advanced research and education more broadly.

"Atlantic has supported us financially," Professor Huong concludes, "but also supported the School in helping us think strategically — how we will develop, and what is the benefit of development, both for the School and for the whole public health field. Because it is not enough for public health to grow and to change. The changing of public health has to fit into the change in the structure of the whole system, and the way it supports the overall health of the people. Public health is an evolving field, and it has a mission in the context of the whole health system of Viet Nam." ■

"ATLANTIC HAS SUPPORTED
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STRATEGICALLY."

—PROFESSOR NYUGEN THANH HUONG

NETWORKING AND COLLABORATION

ANOTHER HALLMARK of Chuck Feeney-style philanthropy has been the forging of working connections among outstanding people his Foundation has supported, linking great minds across institutions, countries, and cultures. At first, he brokered these connections personally, inviting grantees from one country to visit those in another, gathering them for tours, conferences, and informal meals, encouraging them to learn from one another, and helping them create more regular means for professional interaction and collaboration. It was this kind of direct intervention that led to the creation of scholarship programs in Australia for Vietnamese professionals, of which there are several examples in this report.



Later, Atlantic staff in Viet Nam expanded the interaction-and-networking agenda to encompass more formal, durable forums for professional exchange. The Foundation occasionally supported regional conferences and symposia in public health, family medicine, and primary health care around Southeast Asia, or provided the means for leading Vietnamese professionals to attend. Closer to home, it was a core funder of the Viet Nam Public Health Association and has helped to encourage the growth of a National Family Medicine Association as well, though that is newer and, at the time this is written, is still finding its legs.

One example of a Feeney-brokered connection that has grown into a multinational, regional network began with the Fred Hollows Foundation, an organization based in Melbourne dedicated to vision care. In 2003, in one of his periodic visits to Viet Nam, Mr. Feeney set up a meeting with Dr. Pham Binh, director of the then-five-year-old Da Nang Eye Hospital. Also invited to the meeting were representatives of other Atlantic grantees and of the Fred Hollows Foundation, which Mr. Feeney had encountered in Australia, as well as members of the hospital's staff. Dr. Binh, whose English was limited, had asked Dr. Huynh Tan Phuc, a young ophthalmologist who had studied in Australia, to present a proposal for expanded facilities (which Atlantic later funded) and to serve as interpreter.

Michael Lyskey, then the CEO of Fred Hollows, had flown to Viet Nam to attend the meeting in person, not only to learn about plans for eye care in Da Nang, but because he had his own proposal to share with Mr. Feeney. He had in mind a \$5 million initiative to improve primary eye care — routine ophthalmic and optometric services in local settings — across 15 provinces in Viet Nam. He had met Dr. Phuc briefly at international conferences and was impressed with his presentation at the meeting. He approached Dr. Phuc after the meeting to gauge his interest in leading the new initiative, if Atlantic chose to fund it.

SIGNIFICANTLY, MR. LYNKEY was not the only person whom Dr. Phuc impressed that day. Designated to lead Mr. Feeney on a tour of the new hospital, Dr. Phuc brought him to the surgical theater, where a cataract operation was in progress. Mr. Feeney was so engrossed by the procedure and Dr. Phuc’s explanation of it that he asked to stay longer so that he could see the next operation from start to finish. Later, as Dr. Phuc took him from bed to bed, introducing him to post-surgical patients, reading charts, and explaining individual cases, Mr. Feeney found his guide’s obvious concern for the patients and their treatment inspiring.

“In each case,” Dr. Phuc remembers, “he wanted to know the personal care of each patient. Where did the person come from, what age, what problem, the diagnosis, and how would he or she be treated. He was looking at the big picture, but he also understood that, within that picture, the outcome and effect for each person would be to change their lives.”

“Who was that young man?” Mr. Feeney later asked Atlantic’s country director, Dr. Phuong. The director had no idea, but promised to find out.

That day’s encounter among several organizations at Da Nang Eye Hospital led to at least three important consequences. First, Mr. Lynskey and Dr. Phuc began a conversation that soon led to the latter becoming the Fred Hollows Foundation’s country director in Viet Nam and launching the country’s first initiative in primary eye care. Under Dr. Phuc, what had begun as a two-person operation for Fred Hollows in Viet Nam later grew to a team of 25, with a network of physicians trained in primary eye care all over the country. Second, Atlantic agreed to back the initiative, not only in recognition of a sound approach to serving a real need, but because Mr. Lynskey and Dr. Phuc represented a driven, entrepreneurial team in which Atlantic could invest confidently. Third, Atlantic’s support for vision care, which started at the tertiary level, including Da Nang Eye Hospital, soon began a gradual extension into the world of primary care. With the push into primary settings, eye care would not only reach more people, but would help prevent blindness and other vision emergencies that would otherwise have burdened the already-crowded hospitals.

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He was looking at the big picture, but he also understood that, within that picture, the outcome and effect for each person would be to change their lives.” — Dr. Hyunb Thanh Phuc

BEGINNING IN 2005, Atlantic provided a series of grants to Fred Hollows that has led to the creation of a nationwide network of primary care doctors trained in basic vision care. One of those grants, for \$2 million, supported an effort to build expertise in primary care at the Viet Nam National Institute of Ophthalmology. Already the country's leading eye-care institution, the Institute has since grown into a major source of training for primary eye care, in concert with nine medical universities across the country. Other grants, combined with support from the Vietnamese government, have led to the upgrading of local and provincial eye-care clinics, equipping them to treat many more patients with superior services. In Phu Yen province, for example, the local eye center was handling roughly 300 cases a year with a staff of nine. By 2013, its caseload had grown fivefold and its staff had risen to nearly 70.

Today, says Dr. Phuc, Fred Hollows is working in 20 of Viet Nam's 58 provinces. Its goal of ending preventable blindness in Viet Nam by 2020 seems well within reach. Through the Institute of Ophthalmology and other networking forums, providers of vision care — both specialists and frontline family practitioners — form an increasingly cohesive force for leadership and advocacy in the field.

And as for Dr. Phuc himself, his own field of operations is set to grow substantially. At the time he was interviewed for this report, he was days away from becoming Fred Hollows' East Asia regional director, responsible for improving eye care in seven countries, including the Philippines, China, and Indonesia, as well as Viet Nam. With adaptations for individual systems and cultures, says Dr. Phuc, "the vision for Viet Nam can apply to the other countries as well," given a similar effort of networking, training, piloting, and adapting models to local circumstances.

In short, Atlantic's investment in the Fred Hollows Foundation, and in Dr. Phuc in particular, was only partly an effort to provide more primary eye care. Its larger aim, potentially far more significant and affecting may more people, has been to enable Dr. Phuc to extend the Foundation's networks, reinforcing the connections among practitioners in the field, in hospitals, and in academia, along with health officials in government and advocates across a wider region. "So as Dr. Phuc has learned and grown," says Atlantic's Dr. Le Nhan Phuong, "the people affected by his work have also grown. And they in turn are affecting more and more people — training more professionals, hiring more people, treating more patients." ■

SUPPORTING REFORMERS BY INVESTING IN THEIR BEST IDEAS

SOMETIMES, THE SUREST WAY to help talented people advance and achieve more is not simply to direct resources toward the people themselves, but to provide the means for them to prove their ideas in practice. This is an aspect of human capital philanthropy that may be the least obvious, but it is entirely consistent with the goal of infusing fresh energy and creativity into a system's leadership and talent pool. In several cases in Viet Nam, Atlantic put its grants behind exceptional people who later rose into higher positions of leadership and helped to enrich wider and wider circles of activity. But it supported them not primarily by investing in their personal development. Instead, it supported the things they wanted to accomplish — providing a bigger stage on which to demonstrate the potential of the innovations they were trying to advance. To that end, the Foundation continually reconnoitered for outstanding people with original ideas, and then underwrote the means by which those ideas could be brought to life, tested, and replicated. That in turn helped the innovators and their projects win the attention and support of higher-level decision-makers who could take the ideas into the mainstream.

One example, comparable to a number of Atlantic initiatives in other countries, was an effort to build up the health system's means of conducting sophisticated policy analysis and translating it into real benefits for Viet Nam's poor, rural, and minority populations. For half a dozen years, directly and indirectly, Atlantic supported the Health Strategy and Policy Institute (HSPI), a think tank within the Ministry of Health that provides research and evidence-based recommendations for policymakers. Although the Institute was already more than 15 years old by the time its relationship with Atlantic began, it had developed slowly, lingering mainly at the margins of policy debate for most of its history. Despite its efforts, policy still tended to be made subjectively, and was overwhelmingly based on information from hospitals and health care providers about the supply of health services. Information on patients and their needs, the demand side of the health care marketplace, was scarce and apt to be ignored. All of that began to change around 2007, when three overlapping events gave the Institute, and its quest to infuse population data into policymaking, a powerful lift.



THE FIRST was the arrival of Professor Le Quang Cuong as HSPI's director. Professor Cuong had spent 25 years as a distinguished neurosurgeon and professor of neurology before being recruited into the national Health Ministry to lead its Therapy Department, which sets standards of medical practice. Afterward, armed with high-level experience both in direct patient care and national policymaking, he took the reins of HSPI. From his time at the Therapy Department, he knew that the Institute's work was solid — it had received years of support from the Rockefeller Foundation to improve the quality of its research and analysis — but that its influence was peripheral. Its recommendations, he said in later years, had either been “superficially” received (meaning accepted in principle but then largely ignored) or rejected altogether. He was determined to make policy research for the Ministry both high quality and effective.

The second pivotal change was the beginning of a relationship between HSPI and the University of Queensland, brokered and funded by Atlantic. This was essentially the same combination of cross-cultural management consulting and professional training and mentoring that Atlantic had arranged for the Ha Noi School of Public Health, the Hue University of Medicine and Pharmacy, and other leading institutions in primary care and public health. The relationship gave the analysts at HSPI a new way of thinking about how to organize their work strategically and, most critically, how to package and present that work to policymakers in the most persuasive way.

The relationship worked in large part because of Professor Cuong's keen interest in two aspects of policy development that had not yet matured at HSPI: implementation and advocacy. With help from Queensland, and drawing on his own considerable skills in frontline practice and high-level persuasion, Professor Cuong now had both the technical help and the international cachet to change the way his colleagues pursued their mission. Henceforth, HSPI would not only design elegant policy reforms; it would map out practical steps to implement those reforms and place the whole architecture compellingly before the Health Ministry's decision-makers.

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NOT LONG AFTERWARD, in the third helpful development for HSPI, the leadership in Viet Nam's Health Ministry took a pronounced turn toward seeking evidence-based policy. The appointment as Health Minister of Nguyen Thi Kim Tien, a research scientist formerly with the Pasteur Institute, placed the Ministry in the hands of someone whose intellectual home was the laboratory, and whose first questions about any new idea tended to involve the data and the evidence behind it.

This fertile mix of developments provided Atlantic the opportunity to support the quality of HSPI's research, as well as to focus squarely on how that research would translate into actual policy and practice, leading to better care and a healthier population. In addition to the support Atlantic channeled to HSPI through the University of Queensland, the Foundation also supported a request from Professors Tien and Cuong to organize an intensive workshop on evidence-based policy for Ministry officials — in effect, training HSPI's audience to understand and use the Institute's analyses and recommendations. As it prepared to end its operations in Viet Nam after 15 years, Atlantic made a concluding grant of \$1.2 million to HSPI, with a two-to-one match from the Vietnamese government, to fortify its research and advocacy on health equity and the needs of the country's least-served populations.

A key reason for this support, and arguably the critical factor that made it a smart bet, was the presence of Professor Cuong. He had made it his mission to create a policy institute that actually improved policy, and to build the appetite of his Health Ministry colleagues for the kind of evidence and recommendations that HSPI could produce. In that sense, Atlantic's investment and Queensland's support were not aimed at research per se, but at the enterprising leadership of someone who was determined to turn already good research into measurably better health for millions of people. To reach that goal, it was essential to have someone at the helm who understood the Ministry and was able to be an effective salesman for a scientific approach to policy.

For Atlantic — and even more for Viet Nam — the investment has paid off. In 2013 Professor Cuong was promoted to vice-minister of health. He still has HSPI among the units under his supervision, but now he is in a much better position to promote its work across the Ministry and to shepherd its recommendations into policy and practice. Along the way, the Institute has risen in stature and visibility, both nationally and internationally. In a study of six elite health-policy institutes around the world, the World Health Organization ranked HSPI one of the two best. (The other, South Africa's Health Systems Trust, is also a major Atlantic grantee.)^x

ATLANTIC'S INVESTMENTS in the Institute have served three overlapping goals: better policy, a stronger health-research institution, and a cadre of government health executives, prominently including Professor Cuong, who are more attuned to evidence and evaluation. What may appear, on the surface, to have been a fairly abstract kind of grantmaking — focused on data and analysis, epidemiology and economics, computers and spreadsheets — was in fact at its core a human capital strategy, focused on leadership, entrepreneurship, and ambition to make a difference. In fact, only Atlantic's parting grant may pay for computers, software, and other building blocks of research capacity. Before then, all of it was aimed at people, their ability to reckon with evidence, and their appetite for turning evidence into a healthier nation. The ultimate, preeminent goal was to strengthen the Institute and, by that means, to help the Ministry make smarter health policy. But the means to that end were nearly all human — backing the people who would make the change.

The central province of Thua Thien Hue provides another example of an Atlantic initiative whose core tactic was human, even though many of its elements involved complex technical and logistical operations. In 2005 the relatively new director of the province's Health Department, Dr. Nguyen Dzung, traveled 335 miles (540 kilometers) north to pay a visit on Atlantic Country Director Le Nhan Phuong at the Foundation's office in Ha Noi. He had learned of Atlantic's seminal initiatives to transform primary health care in commune health centers in Khanh Hoa and Da Nang, and he had an idea for doing something similar in Thua Thien Hue.

The program he proposed has already been described in some detail (in the early section of this report headed "direct training"). But what made the meeting significant was not solely that Dr. Dzung was interested in something that Atlantic was already deeply committed to — upgrading the medical care provided at community clinics. The truly significant thing, as Dr. Phuong remembers it, was that the new provincial health director was adamantly, even passionately, committed to getting it done. And he had plans for just how to accomplish it.

"This is my job," Dr. Dzung said almost a decade after that first meeting, reflecting on the sweeping reform he has carried out with Atlantic support. "I would have had to do it anyway. There was no other way to provide adequate care without bringing more doctors [to the clinics], raising their skill levels, and supplying better facilities and equipment. But I have to tell you, every year I got only enough budget to help two commune health centers. I have 152 that I am responsible for. At that rate, it might have taken me almost 100 years to do what I needed to do, had it not been for Atlantic."

BUT WHAT ATLANTIC SAW IN DR. DZUNG was something it could not buy with any amount of grant money: a charismatic, determined public official with sufficient authority to create the change he sought, someone highly respected in his province, who thought about the wholesale transformation of primary care not as a dream or an abstraction, but as “my job,” something he would “have to do anyway.”

What Dr. Dzung acknowledged, and Atlantic already understood, was that reforming primary health care at the rate of two clinics a year would perhaps have improved those particular clinics, but it would not have changed the standard of primary care beyond Thua Thien Hue. And it would take the better part of a century to do even that. What was needed was something big enough and swift enough to draw official notice, to prove the feasibility of the concept, and then to start attracting much bigger government investments to complete the job and spread it to other provinces. Carrying out a transformation on that scale is demanding enough; it would call for a first-rate public manager. But making sure it is noticed and appreciated farther up the hierarchy, and that upper-level policymakers respond with bigger budgets and supportive policies, would be nearly as difficult and would take a completely different set of skills. Dr. Dzung had both sets of requirements.

This became clear almost from the moment Atlantic and Dr. Dzung decided to work together. As Dr. Dzung remembers it, the first thing Atlantic’s Dr. Phuong told him was, “If we are going to help you, your financial contribution to this will have to be much higher than it is right now.” Atlantic would foot less than half the bill. The rest would have to come from the government. Dr. Dzung said, “He asked me, ‘Do you think you can do that?’ and I answered ‘Yes.’” This was, in fact, exactly the kind of arrangement Dr. Dzung was hoping for. He knew he could not run an improved primary health care system over the long run with foundation money. If a reformed system didn’t become a mainstream government commitment, it would not be completed and it would not last. He needed someone with international stature and the ability to invest a considerable amount up front in order to overcome official skepticism and uncertainty, and to demonstrate that an improved system would work. As Dr. Dzung summed it up, “With the support of Atlantic, which placed a significant amount of resources on the table, it was so much easier to get matching funds from local government.”



**ATLANTIC WOULD
FOOT LESS THAN
HALF THE BILL.**

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IN EFFECT, he was promising government funding in order to win Atlantic’s support, and promising Atlantic funding in order to win government support. Each side understood the arrangement. Like the best entrepreneurs, he was leveraging all his assets.

The success of Dr. Dzung’s primary care reform has already been described. And although Atlantic later rolled out the model to five additional provinces across every region of the country, two of its earliest experiences — with Dr. Dzung in Thua Thien Hue and with Dr. Truong Tan Minh in Khanh Hoa — still stand out as exceptional achievements. That is in large part because of the extraordinary partnership between the Foundation and the leaders in those provinces. In each case, Dr. Phuong is quick to point out, the impetus for the plan, and the exhausting effort required to see it through, came not from the Foundation but from the provincial health directors themselves. And they, in turn, sought out gifted and committed people among their subordinates with whom to work. The human capital at the heart of the strategy has been not only the health care workers trained at the front lines, and not only the directors who gained an opportunity to demonstrate their ideas and turn them into official policy. The investment also cultivated many middle-and lower-level managers who believed in the plan (in fact, in many cases had been hoping for years for such an opportunity) and carried it out with determination.

Dr. Dzung gives some of the credit for this approach to his partner at Atlantic: “If there is one thing I learned from Dr. Phuong,” he says, “something I have applied very widely, it is to make the work *their* work. While I am the director of the Health Department, in each facility I give them the responsibility. They have to do this, because it’s their work, not mine. I help them, but they have to make it work. So I delegate, but I also make sure that each person has ownership in what they’re doing. And that is the key to sustaining and improving.” Part of that challenge, he acknowledges, is culling the workforce of people who are not committed to improvement. “The first step was to revamp the leadership structure,” he says. “We set standards and credentials for clinic doctors, and we removed the ineffective ones.” But for those who were willing to reach for a higher level of service, “we made sure they got the resources they needed.”

That is essentially the same philosophy, he adds, that governed Atlantic’s approach to dealing with him and with other officials in Viet Nam’s health system. “He has always been very clear about it,” he says, referring to Dr. Phuong. “This is my job, not his job. If Atlantic helps, they would only be helping us to achieve our own goals.”

IN THE NINE YEARS since the Atlantic initiative began in Thua Thien Hue, Dr. Dzung's star has risen, along with the national acclaim for his transformation of primary health care. A turning point of sorts came when the General Secretary of the Communist Party, Viet Nam's most powerful public figure, canceled a visit to an elite medical center so that he could join Dr. Dzung on a tour of primary care clinics in Thua Thien Hue. Not long after, at a national meeting of health officials, according to Dr. Dzung, the Minister of Health "repeatedly said that the primary health care system in Thua Thien Hue is the best in the country, and that any province that wants to learn should come here and see it. And many provinces have in fact come to learn from us."

On July 17, 2014, Dr. Dzung was elected vice-chair of the Thua Thien Hue People's Committee, the second-highest-ranking public official in the province. His responsibilities continue to include health care, as well as education and other matters. But he now has budgetary authority — a power he formerly could harness only by pleading, prodding, and enticing his superiors to take note of his ideas. As happened in the cases of Professor Cuong at the national Health Ministry, of Professor Huong at the Ha Noi School of Public Health, and of many other people in whom Atlantic recognized exceptional talent, its human capital investment in Dr. Dzung ended up being multiplied by his rise to higher and wider authority.

And Dr. Dzung believes it has paid off for him as well. "For each of us," he said at the end of a reflection on his years working with Atlantic, "it is rare that we have the chance to do something really significant in life. And when you do have the chance, you seize it. You do it with all your heart." ■

"...It is rare that we have the chance to do something really significant in life. And when you do have the chance, you seize it. You do it with all your heart." — Dr. Nyugen Dzung

CONCLUSION:
WHAT MAKES HUMAN
CAPITAL DIFFERENT?

CONCLUSION

IF NEARLY every grant involves a deliberate wager on human talent, then it's useful to ask: Are there grants that are *distinctively and primarily* human capital in nature? In other words, is there a definable category of grants whose main purpose, or theory of change, or return on investment — pick any popular metaphor — is to help produce smarter, wiser, more accomplished, more consequential people? And if so, what constitutes excellence in that kind of philanthropy?

To be sure, some kinds of grantmaking are obviously and purely human: endowed academic chairs, art commissions or patronage, individual fellowships. But many other things that may seem focused on human talent actually keep their human capital calculation at one or two degrees of distance from the main goal. For example, grants to research scientists seeking a cure for disease are certainly major bets on those scientists, but that is not usually their main purpose. The disease, not the researchers, lies at the center of the strategic target. Grants to a school district for education reform are (or should be) calculated investments in the teachers and administrators who will carry out the reform. They are also investments in the enriched lives of better educated children. But, for the grantmaker, the top-level consideration, quite often, is not the individuals in any given school or classroom; it's the public policy lessons to be learned, and the testing of models and practices that can later be replicated across whole systems.

So where *is* the boundary between the human return and the scientific, social, educational, or public-policy return? In practice, it probably lies in a slightly different place in every grant. Even among grants with very similar purposes, the line can fall in a different place each time. For example, support for a policy think tank may, in one case, be aimed primarily at boosting the political influence of particular scholars and advocates who happen to work there; but in another case it may be primarily aimed at developing or promoting some favored policy, with the individual researchers and analysts coming and going as needed. The same foundation may well make both grants with ultimately the same policy goals in mind. Consequently, at the level of individual grants, there seems to be no clear, bold line that consistently distinguishes a human capital grant from other kinds.

BUT AT THE LEVEL OF a *program* or *initiative* — i.e., clusters or sequences of grants pursuing a single strategy for longer-term ends — it is possible to define a distinctively human capital approach. And within that defined effort, it is possible (in fact, as this paper has tried to show, it is desirable) to blend some grants that are overtly and primarily human with others in which the human element intertwines with other purposes. The distinguishing factor is the definition of the problem to be solved.

In a human capital program, the primary diagnosis is that desirable outcomes are being impeded by one or more *talent gaps* in a system or field — areas where a shortage of creativity, skill, leadership, advocacy, or some combination of these is a critical obstacle to greater achievement. “Achievement” may be defined in many ways — for example, it might ultimately have to do with finding a scientific breakthrough or encouraging the appreciation of poetry. But if the strategy rests on the determination (a) that a field fundamentally needs more talent, or needs to promote the talent it already has, (b) that helping some gifted people to advance will, in turn, lead to the attraction and training of even more talent, and (c) that philanthropy is needed to help train, network, spotlight, or promote those pivotal people, then the initiative can fairly be classified under human capital.

What makes this “capital,” as opposed to simply human “resources,” is point (b). A human *capital* program is designed to produce a flow of returns in the form of more and more people with skill coming into the field, producing socially valuable outcomes, and in turn attracting and nurturing the next wave of talent. Dr. Bui Duc Phu of Hue Central Hospital summed up this proposition succinctly: “We have trained a generation of experts who can then train future generations.” Supporting a cadre of educators, institutions, networks, or leaders who inspire, mentor, and attract others, are all ways of *leveraging* talent, not merely rewarding it. That is, this kind of support invests in a few people who, if wisely chosen, will in turn cultivate many. In Atlantic’s Viet Nam program, as Professor Nguyen Minh Tam expressed it, the essential, underlying health care calculation had three “cornerstones:” a need for better leadership, for better infrastructure (buildings and equipment), and for more training. Two of these are obviously efforts to fill talent gaps: the cultivation of creative, reformist leaders, and the training of health care workers. Both of them create engines for additional cultivation and training of more and more people, in a kind of virtuous cycle. But even the infrastructure element, as the programs in Thua Thien Hue and Khanh Hoa demonstrated, were really aimed squarely at multiplying talent. Clinics were upgraded not solely to improve patient care (though that was obviously an important benefit), but to create an environment where better-trained doctors and staff would want to come and work, remain, excel, and advance.

IN BUILDING the fields of family medicine and public health, Atlantic’s primary strategy was to populate these fields with gifted people at three main levels: the frontline workers, the educators who would train and inspire them, and the policymakers who would fund their efforts and incorporate those efforts into mainstream health policy. Again, the principal calculation was that all three of these levels had gaps in training, education, and experience that needed to be filled. Starting with the available human resources — small cadres of professors and policymakers committed to what were then still niche fields — Atlantic offered opportunities to hone their mastery of the relevant disciplines and then, equipped with elevated skills, credentials, and cachet, to rise in the ranks. The Foundation paid for international mentoring and scholarship, opportunities to network with experts and peers, consulting services to improve the institutions where they worked, and evaluations to demonstrate the effectiveness of their efforts.

Without question, the end purpose of all of this was not to boost particular people’s careers; it was to build a healthier and more equitable Viet Nam. But boosting careers — selecting, training, and retaining the most visionary and enterprising people — was the principal tactic to that end. And that is why the Foundation could report unequivocally that “the entire Population Health Program in Viet Nam is designed around the kernel of human resources development.”

And when that is the case, the matter of evaluation likewise becomes fundamentally about human achievement: How many better-trained people now work in the places targeted in the strategy as needing talent? How long do they stay, and what do they say about their work-life and environment? How have the budget and personnel deployment changed in agencies now run by foundation-supported leaders? What has happened to enrollment and career placement at universities and training academies that received grants? Most important of all, are more people receiving essential services that used to be scarce or inadequate? All of these questions are incorporated into Atlantic evaluations, several of which are still ongoing. The results so far are highly encouraging, though as in any human endeavor, there are weak spots and caution lights. But the main point, for the purposes of this discussion, is that human factors are at the heart of the questions being asked. And that, too, is a logical hallmark of human capital philanthropy as we have defined it here.

Even if, as Mike Sviridoff once said, “all successful grants are investments in people,” not all successful grants are meant *primarily* to develop human capital. Spotting talent gaps that are impeding desired outcomes, figuring out how to fill them, and recognizing the human gifts that equip people to lead the charge — all of these are special kinds of philanthropic skill. They are useful in any branch of grantmaking. But they are indispensable for any foundation program that is, at its core, “designed around the kernel of human resources.”

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- ⁱ Adam Smith, *An Inquiry into the Nature and Causes of the Wealth of Nations*, London: Methuen & Co., Ltd., 5th edition, 1904, accessed 1 August 2014 at the Library of Economics and Liberty: <http://www.econlib.org/library/Smith/smWN6.html#>
- ⁱⁱ I was present for these remarks. The quote is taken from a notebook I kept at the Ford Foundation from 1978 to 1980, which include many comments from Mr. Sviridoff.
- ⁱⁱⁱ "From Communities and For Communities: The Atlantic Philanthropies' and Viet Nam's Efforts to Develop Human Resources in Health," The Atlantic Philanthropies, 2014, p. 17.
- ^{iv} *Ibid.* p. 5 (emphasis added).
- ^v Le Nhan Phuong, "Khanh Hoa Provincial Health Department, in Support of Improving the Commune-level Health System," a grant recommendation submitted to the Board of Directors, The Atlantic Philanthropies, September 2003, p. 1.
- ^{vi} "From Communities," , p. 19.
- ^{vii} For a fuller discussion of the role of facilities and equipment in supporting human capital, see *Laying Foundations for Change: Capital Investments of The Atlantic Philanthropies*, The Atlantic Philanthropies, 2014, pp. 40-48.
- ^{viii} Tony Proscio, "The Atlantic Philanthropies in the Republic of Ireland, 1988-2010," unpublished manuscript, July 2011, p. 5.
- ^{ix} Bui Duc Phu, in *Laying Foundations for Change*, p. 207.
- ^x Trinh Huu Tuan, "Equity in Health: The Atlantic Philanthropies and Disadvantaged Populations in Viet Nam, 2003-2013," The Atlantic Philanthropies, 2014, p. 55.
- ^{xi} "From Communities," p. 5.