Robert Wood Johnson Foundation

Health Care's All-American Journey: This is But the End of the Beginning

President's Message

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Nearly four decades ago our namesake set our Foundation on a mission to improve the health and health care of all Americans. From the beginning, we embraced our long-term philanthropic charge to help Americans lead healthier lives and get the quality of care they need.

And, as current events demonstrate, large-scale change comes loaded with uncertainty, conflict, controversy and the full-throated commotion of strong ideas strongly expressed. In other words, the great national debate over health care is nothing less than all-American democracy at peak volume.

This debate is nothing new; indeed it is decades, even a century, old. It framed the policy picture during our first full year of operation when President Nixon proposed his own national health insurance strategy.[1,2] Lessons we learned from way back then continue to serve our practice of philanthropy today. We vigorously adhere to our founding principle of nonpartisan independence, staying outside the fray even in the most fractious of times. In the meantime, we sustain the research, build the evidence, test the models and measure the progress and impact of health systems changes and population health improvements that our mission demands, regardless of the surrounding political sound and fury. And given that we are not beholden to shareholder or political constituencies, our programs and grantees have the benefit of a patience that eludes the corporate and government sectors.

Our experience across two generations confirms for us that in philanthropy, as in most of life's meaningful endeavors, timing truly is everything. In fact, hindsight reveals that much of the story of our Foundation's extended family of grantees, partners, allies and stakeholders is a still-unfolding narrative of preparing for the moment when American society crosses its own threshold for change.

Our first president, Dr. David E. Rogers, the renowned dean of Johns Hopkins Medical School, put it this way:

> "To effect workable social change, we believe the RWJF's grant program must also be realistically timed to coincide with the readiness of society to take action."

A big part of our mission, accordingly, is to pave the way through research and pilot programs; convening even the strangest of bedfellows; informing the debate; educating the public and policy-makers alike; and unifying the far-flung field of health care's trailblazers. And from time to time there has even been a bit of the zealot in us. That's probably a good thing because it takes enthusiasm, energy and conviction to stay a course that has challenged and confounded so many for so long.

THE LESSONS OF HISTORY ARE HARSH. For longer than living memory, the road to improving America's health insurance and health care systems always ended at a seemingly impassable dead end. Society simply wasn't ready to reset so critical a cornerstone of daily life. As a result, little changed through the administrations of 16 U.S. presidents and 49 consecutive sessions of Congress. On average, about every 15 years someone mounted a serious attempt to improve upon the status quo. The times were never right. Each time they failed.

The Wall Street Journal rightly called it "the hundred years' war over national health insurance."[3] Some of the battles—1993 to 1995, for instance—were epic, literally shaking the foundations of health policy and national politics and dividing the country along jagged ideological fault lines. Citizens and leaders alike became skeptical, even cynical. The nation's nerves frazzled, patience faded, tempers shortened. Meanwhile—impervious to politics and resistant to interference—the entangled problems of coverage, quality and inequality of care, prevention, spending and costs agitated toward critical mass.

In other words, the winds of change were gathering. You could literally sense the coming storm. In my annual message just a year ago, we alerted our grantees and partners that health reform's time was near. We told them that:

> "In this new century, history dares us to face up to the changing conditions of our generation's America and fix what is broken, discard what has failed, and accomplish what is needed and new . . . We can do this, even if it means changing the world around us and changing ourselves in the process. The evidence is in, and the time to act is now."

WELL, HERE WE ARE, A YEAR LATER and, as predicted, the country is opening the first chapter of a whole new era for health care in America. *The Patient Protection and Affordable Care Act* is law. That doesn't mean it is time to close the book.

"This is not the end," Churchill would remind us. It is merely "the end of the beginning." As the fire and heat of the recent debate gradually abates—and it will—our nation's public health and health care systems are already turning toward the immense implementation task ahead.

Make no mistake, though. Clearly, not everyone is happy. If there is one thing universal about the new law it is the common agreement that it is far from perfect. Ongoing opinion polls show the public, like their political leaders, remains deeply divided. Differing ideological approaches to governing remain in conflict. Even the most neutral of experts remain uncertain of what lies ahead. What is certain is that the fields of health and health care are bracing for change of intense magnitude.

The next chapter, then, will be a how-to manual for revising, retooling and re-engineering. The complexities are confounding, solutions controversial, and consensus on how best to do it virtually beyond reach.

In the doing will come much learning. Consider just some of what remains unresolved:

- Yes, the law does come close to opening doors to coverage for all Americans, but whether we can pay for it all without deepening the deficit remains a matter of debate.
- The efficacy of expanding state Medicaid programs for the poor by slowing the growth of national Medicare spending is no slam dunk. And many governors say they can't pay for expansions, no matter what.
- Left unaddressed, as always, is the smoldering problem of our dysfunctional medical liability system and the paired problems of defensive medicine and high-cost medical malpractice insurance premiums, which dispirit so many physicians.
- Neither the public nor private sector has experience signing up more than 30 million people for health insurance in such a short time.
- The surge of so many new patients may destabilize the capacity of already-stressed providers in areas with high numbers of uninsured people.
- There is as yet no blueprint for building the all-new health insurance marketplace where consumers and small businesses can shop for coverage.
- The law declares prevention and wellness as national health priorities but makes no assurance that the promise of better funding can or will be kept. Righting the funding imbalance between sick care (95%) and well care (5%) will take coordinated and concerted action.
- And then there are the unintended consequences, the fallout from any policy change that must be uncovered quickly and fixed …

THE IMPLICATIONS ARE PROFOUND for the Robert Wood Johnson Foundation and our community of grantees, partners and other stakeholders. For those of us who have labored in this field for so long, the realistic prospects for positive change are breathtaking. This is our mission. As my immediate predecessor, Steve Schroeder, likes to tell us, "execution trumps strategy."

What we do next will define our programming and resource allocations through the next several years. The priorities we are setting and choices we are making will:

- Influence the direction of our fields of activity through at least the next five years. For example, we are preparing now for advance research to make sure insurance exchanges function properly when they start enrolling people in 2014.
- Affect the pace and competence of the health care sector's implementation of expanded health coverage and adoption of quality policies.
- Bring greater value to the dollars spent on health care.
- Influence the prospect of future strategic and systems improvements that directly impact the health of Americans, such as preventing illness and injury, promoting wellness, strengthening public health and disaster preparedness, and transforming the social factors affecting health, such as education, into assets for every community.

We are organizing our work through at least 2015 around six mission-centered domains of strategic action. They are . . .

MISSION: TO IMPROVE HEALTH CARE FOR ALL AMERICANS

1 **Cover the Uninsured**

2 **Bring Down Spending**

3 **Improve Quality, Value and Equality of Health Care**

MISSION: TO IMPROVE THE HEALTH OF ALL AMERICANS

4 **Prevent Disease and Promote Healthier Lifestyles**

5 **Strengthen Public Health**

6 **Address the Social Determinants of Health**

These are the strategic frames that align the Foundation's mission with the intent and goals of *The Patient Protection and Affordable Care Act*. Though each domain represents a distinct sphere of need, innovation and solution, each domain also is intricately tied to the others.

The purpose of the six domains is not to implement the law—we don't do that—but to equip grantees, the health sector and the public with the evidence of best approaches, practices and constructs. Together, the domains outline how we will help Americans bring the new law to life.

The six domains place our vision, initiatives and perspective in the context of new health care law.

1. Cover the Uninsured

Securing stable, affordable coverage for all Americans is a core objective of our mission to improve health and health care.

The past year's political debate and legislative action established coverage as a principal gateway to other reforms and is consistent with our coverage principles and our belief that:

- Good health is necessary for all Americans to participate fully in society, and a healthy population is vital to the productivity and economic and social well-being of our nation.
- Health care is critical to good health and should be available to all regardless of race/ethnicity, age, gender, geography or income.

Ninety-four percent of all citizens and legal residents below Medicare age eventually will have access to health insurance—a big jump from the current 83 percent. To get there, the new law:

- Expands coverage to more than 32 million people currently uninsured.
- Requires everyone to have health care coverage.
- Bans exclusions for pre-existing conditions, loss of employment or gender.
- Allows young Americans to stay on parents' plans until age 26.
- Opens Medicaid to more of the working poor and children.
- Provides subsidies to help the working poor buy insurance.
- Introduces state-based insurance exchanges.
- Allows states the option of merging individual and small group markets.
- Establishes a baseline health benefits package that makes comprehensive services available to everyone.

Execution will be challenging. As a nation, we must learn from failure as well as from success.

- Monitoring and evaluation are critical. Not every program will succeed.
- Research will identify how best to enroll as many people as possible. One size will not fit all regions or demographics.
- RWJF will refine existing research and demonstration programs and create new ones to get the best and latest information to the field.
- States will need continuing technical assistance. RWJF will be there.

This is familiar territory for us. Since the late-1990s, we have tested, analyzed, and interpreted major coverage advances.

- Our long-running Cover the Uninsured campaign raised early awareness of the causes and effects of living without health insurance, converted traditional adversaries into allies for change, and helped open the way for dialogue and resolution.
- RWJF-funded research documented the costs and consequences to society of more than 40 million uninsured people.
- The research guided us in helping states to identify, enroll and retain eligible children in Medicaid and CHIP through Maximizing Enrollment for Kids, our partnership with the National Academy for State Health Policy.
- Foundation-supported policy research and analysis measured the effectiveness of different approaches to covering the uninsured.

RWJF's platform of experience and network of partners position us to help guide the nation through a challenging period of transition, continue efforts to expand coverage to those still uninsured, and to remind Americans that coverage is not a universal remedy for *all* that ails our health and health care.

Coverage alone will not improve the health of our people and their communities.

2. Bring Down Spending

Supply-side health care is breaking the bank.

- Economists call for "bending the cost curve."
- The system's reflexive answer is to focus on the cost of care and not on the value received for what we spend.
- The traditional solution: cut payments and deny services, thus sacrificing value and patient outcomes to the bottom line.
- The cost curve always snaps back once the system adjusts to its built-in demand for higher and higher margins.
- The market accordingly relies on higher-volume, high-priced care, regardless of necessity, cost or results.

The new law explores more value-based approaches to pay for health care. These approaches are designed to:

- Test the principle that national policy-makers can expand coverage *and* simultaneously reduce the deficit.
- Shift public programs from fee-for-service to compensation based on efficiency and patient results. Medicare pilots are under way now.
- Encourage states to reward doctors and hospitals for treating Medicaid patients with quality care at lower cost.
- Penalize providers who deliver subpar care.
- Establish accountable care organizations, or ACOs—quality-driven alliances of doctors and hospitals—to coordinate care for Medicare patients and to share in cost savings.

The law does carry major limitations. For example:

- Ambiguity about innovative approaches like medical homes and ACOs may limit the full participation of nurses and others just when we need them most.
- Left untouched is a long-standing formula—widely considered flawed—that mandates a 21 percent reduction in what Medicare will pay for physician services in 2010, with additional reductions in coming years.
- Payment innovations are mostly in Medicare and Medicaid, which in 2008 represented 35 percent of all national health expenditures. Their share will push 50 percent by 2019, based on CMS projections released earlier this year.[4]
- Most private sector health expenditures are not directly addressed by the new law. RWJF strategies and programs, such as *Aligning Forces for Quality,* will have high impact on private sector practices.
- Missing are measures to determine if improvements in the population's health demonstrably reduce the demand for care, thus reducing expenditures.

Future RWJF-funded research will measure the impact on spending and costs. We will ask, for example:

- If we improve access and health, will we lower the demand for care?
- If we lower the demand, will expenditures come down, too?
- If spending decreases, will costs follow suit?
- If the payment structure changes, will patient care suffer?

Bottom line: Responsibly reducing demand for care and volume of care will reduce spending and lower costs.

3. Improve Quality, Value and Equality of Health Care

Improving the quality of care is the toughest domain.

- The new law comes the closest ever to articulating a national strategy for quality improvement.
- The law recognizes that quality—unlike expanding coverage and controlling costs—cannot be legislated into existence. Incentives, however, *can* be legislated and regulated.

Rewarding results promotes higher quality:

- Our taxpayer-funded public health care programs are exploring paying providers based upon quality, value and outcomes rather than solely on the inefficient and costly traditional fee-for-system method.
- As this movement builds, the new law recognizes the need to harmonize public and private sector payment approaches.
- The law builds on continuing RWJF-funded research into performance-based payment strategies that value the *quality* of care instead of *more* care.
- The Centers for Medicare & Medicaid Services' (CMS) new Innovation Center is expected further to shape the health sector's shift from fee-for-service to performance-based reimbursement models.
- Important sections of the new law include reducing unnecessary tests and treatments through new research on which medical treatments work best; improving management of chronic diseases; paying hospitals based on quality performance and entire episodes of care; and cutting payment levels for hospitals with higher patient infection rates.
- Another major step forward: Federal funding later this year will set up a nonprofit Patient-Centered Outcomes Research Institute to compare the clinical effectiveness of different medical treatments.

RWJF is well positioned to significantly advance quality improvements envisioned in the new legislation.

- Foundation-funded programs helped define the state of the Quality Improvement (QI) art and established the movement's credibility among academic, government and marketplace skeptics.
- Key advances have come from RWJF's ongoing investments in the National Quality Forum, nursing, chronic care, positive deviance initiatives, MRSA prevention partnerships, and the spread of health information technology.
- RWJF quality and research innovators affecting the reform debate include Don Berwick at the Institute for Healthcare Improvement, Beth McGlynn at RAND, Ed Wagner with the Chronic Care Model, and Jack Wennberg and Elliott Fisher at the Dartmouth Atlas Project, among others.

Our landmark *Aligning Forces for Quality* (AF4Q) initiative is empowering local leaders to create functioning quality-centered health care markets where none existed before.

- We have made a long-term commitment in targeted communities to lift the quality of care, reduce racial and ethnic disparities of care, and convert market competitors into collaborating partners for the benefit of the entire community.
- Our partners are 17 local and regional health care markets comprising 11 percent of the U.S. population. See *www.forces4quality.org/welcome.*

AF4Q will prove to be a classic disruptive innovation that interrupts and disrupts old, ineffective ways of delivering health care services and brings about a radically different, impressively better way.

- AF4Q asks the people who get care, give care and pay for care—to work together toward common, fundamental objectives that lead to better care.
- Our hope is that AF4Q will become a national template for health care market reform, drawing federal resources and spreading across the country.

It takes system change, innovation *and* a social movement to improve quality.

4. Prevent Disease and Promote Healthier Lifestyles

Americans are not as healthy as we could and should be, despite spending more on medical care, as a percentage of gross domestic product and in total, than any other nation:

- Health is more than health care. Most preventable deaths (85% to 90%) result from behavioral, social and environmental factors beyond medicine and health care.[5]
- Yet, 95 percent of national health spending goes to medical and health care services. Barely 5 percent is spent on preventing what sickens, injures and kills us in the first place.

The new law sets up a national prevention and wellness strategy. The strategy relies on an evidence-based approach.

- Build upon what works.
- Test new program and policy approaches to prevention and wellness.
- Ensure accountability by evaluating new programs.
- Use results to prioritize prevention and health.

The law authorizes at least $15 billion over 10 years for prevention programs. Such funding would give traction to:

- Community grants to reduce chronic disease and health disparities.
- Public health and prevention research.
- National campaigns to promote prevention and wellness.

Important and long overdue prevention provisions include:

- Free annual Medicare wellness visits and personalized prevention (Medicare patients have been limited to a one-time-only physical exam).
- State Medicaid coverage for smoking cessation.
- Private plans that cover an annual exam without deductibles or co-pays.
- Funding for exercise, smoking cessation and nutrition education.
- Nutrition information on chain restaurant menus and vending machine food.

Prevention is always better than treatment.

Childhood Obesity: Special Prevention Alert

America's childhood obesity epidemic is the nation's most serious health challenge.

- Obesity is now an equal, if not greater threat to health than smoking.[6]
- More than 30 percent of all children and nearly 70 percent of all adults are overweight or obese.[7]
- Obesity-related diabetes are rising among all ages.
- The prevalence of chronic obesity-related illnesses like diabetes, hypertension, heart disease, and physical disabilities will strain the capacities of providers and government.

The toll on individual and community health will be staggering unless the childhood obesity epidemic is reversed.

- Some experts warn that, if obesity rates continue at their present pace, the United States will spend $344 billion a year on obesity-related health care by 2018.[8]
- Some analysts predict that, within this decade, the costs of caring for obesity-related illness could make up more than one-fifth of the nation's health care spending.[9]

Three years ago, RWJF committed $500 million to reverse the childhood obesity epidemic by 2015. Early results hold promise.

- Childhood obesity prevalence may be stabilizing, with a recent federal report showing a drop in obesity rates among children ages 2 to 5.
- Despite the positive news, we cannot pull back.
- Overall rates of childhood obesity and overweight remain critically high. Racial and ethnic disparities remain persistent and severe—and unacceptable given our mandate to improve the health and health care of all Americans.

New federal legislation, funding and national initiatives reflect what RWJF and its grantees have learned about preventing obesity and promoting good health.

- Grants for the prevention of childhood obesity and chronic disease help reduce health disparities in poor communities.
- Grants help small employers provide wellness programs to employees.
- Menu-labeling regulations will now apply to big chain restaurants.
- Increased funding would accelerate scientific research on the most effective interventions to prevent and reduce obesity.
- Obesity screening and counseling will be covered by private insurers and Medicaid.

The work of RWJF and our grantees will intensify over the next five years as we approach our 2015 target for reversing the epidemic.

- We will carry the message: Maintaining a strong national voice and presence. Educating policy-makers about the importance of healthy communities—and how to create them. Transforming the practices of schools, communities and industry.
- We will support the field: Unifying and leading the many diverse groups working to combat obesity. Sustaining research on how environment and policy can roll back the epidemic. Championing evidence-based programs and approaches locally, regionally and nationally.
- We will broaden collaborations and build partnerships: With other philanthropies and health and medical organizations. With schools, communities, businesses, and the food and beverage industries. With the faith community and government.

We cannot fail, for both health and financial reasons.

- We cannot afford the future human and fiscal costs of obesity. Nor can we allow millions of young people to experience a lifetime that is so compromised or cut short.
- The reward will be a future in which children and families live healthier, longer, happier and more productive lives.

5. Strengthen Public Health

The nation's public health sector, our first line of defense against disease and health-related disasters, is experiencing a fiscal and operational crisis of its own.

- Federal funding for public health emergency preparedness declined by 27 percent between 2005 and 2009, which left states vulnerable during the outset of the H1N1 outbreak.
- More than half the states report a total of nearly 30 percent in combined funding cuts; 23,000 jobs have been lost in public health departments.[10]

The diversion by most states of millions of tobacco-settlement dollars from programs to reduce tobacco use further undercuts the health of the public.

- The Campaign for Tobacco-Free Kids reports that states cut tobacco-prevention funding by 15.4 percent in the past year.
- States will collect $25.1 billion in tobacco settlements and taxes in fiscal year 2010. Breaking from CDC guidelines, however, they will spend just 2.3 percent of that on tobacco prevention and cessation.
- The CDC, meanwhile, estimates 443,000 people will die in 2010 from smoking or secondhand smoke and smoking will contribute $193 billion to our national health care bill.

RWJF, partnering with the CDC, is funding the Public Health Accreditation Board and the nation's first voluntary national accreditation program for state, local and tribal public health departments.

- Our purpose is to improve and protect the health of the public by improving the quality and performance of local, state and tribal health departments.
- The national program will launch in 2011. Early beta testing is under way in 30 health departments across the country.
- Our goal is that 60 percent of the population will be served by an accredited agency by 2015.
- With accreditation, people across the United States can expect the same high quality public health services and level of public health security no matter where they live.

RWJF supported a break-through advance in assessing the health of each county in the United States and making the information available to everyone.

- The County Health Rankings: Mobilizing Action Toward Community Health (MATCH) were released this spring in conjunction with CDC, ASTHO, NACCHO, and other public health organizations. More than 95 percent of all counties are profiled.
- MATCH is a break-through measure for public health officials to identify for state and local leaders what is necessary to improve the long-term health of their communities.
- All data is publicly available through a user-friendly Web site at *www.countyhealthrankings.org/*.
- Within two hours of its launch, *county health rankings* became the number one search term on Google, drew over 150,000 visits, followed by hundreds of news stories, thousands of blog posts and 22 state press conferences.
- At last, the public health field has the tools to connect the dots among:
  - The hard facts of each county's specific health profile;
  - The capabilities public health agencies and stakeholders have and need to improve health, including information technologies;
  - Existing programs, policies and laws that influence health, healthy decisions and health outcomes.
- We expect MATCH will help reverse public health's decades-long neglect by policy- and budget-makers at all levels and open the way to improved individual and public health throughout the country.

RWJF's long and deep involvement with the public health community positions local and state agencies to accommodate anticipated federal enhancements quickly and effectively. In the coming years, our work will focus on:

- Strengthening performance and accountability.
- Building a collaborative public health information system.
- Modernizing state public health laws.
- Developing the next generation of public health professionals.

Public health at last is getting the attention and respect it deserves.

6. Address the Social Determinants of Health

The new law acknowledges that where we live, work, learn and play has an enormous impact on our health.

- Rapidly accumulating evidence relates the all-American creed of individual responsibility to the social and economic forces that strongly influence the personal life and behavior choices we make—whether we consciously know it or not.
- These influences include family dynamics, income and economic status, education, places of birth and residence.

The law's national health strategy tracks the 2009 recommendations from the *RWJF Commission to Build A Healthier America.*[11]

- The *RWJF Commission* laid out ways to improve the population's health by advocating good health in all policies and places.
- The *Commission* found the strongest evidence for interventions that can have a lasting effect on the quality of health and life in programs that promote early childhood development and that support children and families.

At long last, a federal law *(The Patient Protection and Affordable Care Act)* provides a national blueprint on how to give kids a healthy start and a better chance for longer, healthier lives.

- At home—in strong, loving families and in neighborhoods having sidewalks safe for walking and grocery stores with fresh vegetables.
- At work—with jobs that don't demand hours of commuting and in work places free of unnecessary hazards.
- At school—where good education means healthy food, snacks and drinks, plus safe classrooms, cafeterias, playgrounds, and travel to and from home.
- At play—conserving time and resources to strengthen our hearts and immune systems by relieving health-threatening stress through play and relaxation.
- In government—federal law now requires relevant executive cabinet agencies to make sure their policies affect the health of our people for the better—and not for the worse. But what about state and local governments?
- Affected agencies range from Agriculture to Transportation to U.S. Department of Housing and Urban Development to Homeland Security, the State Department, and the Environmental Protection Agency.

Our own work within this domain is profoundly important because of the original intent of Robert Wood Johnson.

- Our founder expressed a near-prophetic understanding that the health and well-being of society's most vulnerable people were especially susceptible to external socioeconomic forces beyond their control.
- He chartered this Foundation to find solutions.
- The Foundation has a depth of experience and breadth of hard evidence acquired over time that suggests workable approaches are within reach.

Our grantmaking during the upcoming years will purposefully target potential solutions. We aim to:

- Reverse deadly health and societal trends, such as violence, unemployment and inadequate education affecting high-risk young men.
- Strengthen the inherent resilience of young people in dealing with a hostile environment that impedes development, discourages improvement and undermines hope.
- Promote realistic ways for young people to overcome challenges to their physical and psychological good health, such as the effect of violence in their lives.
- Spread proven programs that offer visionary, but practical, methods to overcome problems that seem intractable. Good examples are PlayWorks and the *Nurse-Family Partnership.*
- And all the while, bring good health to all policies and places.

All Americans should have the opportunity to live long, healthy lives, regardless of their income, education or ethnic background.

Beyond RWJF's Domains: The Power of People and Ideas

Outside the dimensions of any one domain is the Foundation's long-term investment in people and innovation.

- Change requires leaders and pathfinders to guide the rest of us toward where we need to go, no matter how good the policies, legislation and resources.
- The coming years will require leaders who are strategic, collaborative, low on ego, high on courage, comfortable engaging across multiple sectors, and unreservedly devoted to the common good.

RWJF's most rewarding and longest-running success is how we identify trailblazing innovations and develop transformative leaders with the expertise, vision, audacity and stamina to improve society.

- Our Human Capital and Pioneer Portfolios are the hinges upon which our philanthropy opens to our way forward. These Portfolios function across all domains, resisting pigeonholes and silos.
- Human Capital will remain our largest portfolio for the foreseeable future. This next cadre of leaders will extend the road to reform far beyond the visible horizon.
- Pioneer, meanwhile, provides the seed corn for the breakthroughs of tomorrow that will carry the rest of us along the way.

RWJF HOLDS AN ENORMOUS INSTITUTIONAL STAKE IN WHAT COMES NEXT. We have invested well over $8 billion in both sides of our mission's Health/Health Care equation. As a major independent, nonpartisan philanthropy, we are widely considered to be an impartial leader in improving health and health care in America. We embrace the truth that with leadership comes responsibility:

We have a responsibility to seize this moment. The window of opportunity for health care reform has been nailed shut for one hundred years. Though pried open, there are still no guarantees how long it will stay that way. We've worked toward this moment too long to have the window slam shut before progress is secured.

We have a responsibility to rise above the conflicts, controversies and ideological restraints that too often preclude the conventional public and private sectors from fully meeting the needs of the common good. Philanthropies such as ours are America's "third sector"—a neutral, trusted presence unshackled from the disputes and divisions that repeatedly repel change. For a century health care's major players conditioned themselves to the old zero sum game of all or nothing. Hopefully, times are changing. It is up to us to stay cool, help the combatants, depolarize the environment, and convert yesterday's adversaries into allies mutually devoted to instituting health reform as a convention of our society's good health.

We have a responsibility to stay on course. In today's world of perpetual interconnection, social movements rise and fall overnight on the web of social networking. Winners are as instantly toasted as losers are instantly toast. "Back in the day" is as recent as yesterday. Brands are embraced more as household members than as household names. The seemingly urgent temptingly distracts from the obviously important. The risk of losing one's way is high. We must keep our collective compass set on True North.

We have a responsibility to convene, connect and collaborate. We are old hands at turning "strange bedfellows" into effective partners. I think of the tobacco control movement and our early Cover the Uninsured campaigns. Now we are called to do it again. But not in the same old ways, because "same old-same old" doesn't work so well these days.

We have a responsibility to find and cultivate common ground. Common ground is the garden where we sow the seeds of common good. Unfortunately, common ground is too often a lonely place these days. No wonder. The sacrifices, stresses and fractures of the past two decades have polarized so many that the urge to stand and fight is routinely more appealing than our more pacific responsibility to reflect, reconcile and collaborate.

We have a responsibility to be patient. It will take time—lots of time—for the principles and provisions of reform to effectively work their way into the daily routine of families and schools, business and industry, hospitals, doctor offices, community clinics, public health departments, the back rooms where bureaucrats work the numbers and the C-suites where administrators plot the next right thing to do. Make no mistake, health care's major players are an impatient force susceptible of defaulting to "my way or no way" behavior. We accept the proposition that it is our role to calm, coordinate and cooperate with them all.

LOFTY WORDS? They need to be if we are to meet the aspirations of our ultimate responsibility to be true to the purpose that brings us here in the first place. The truth, you see, is that society doesn't change us. We change society. The playwright Eugene Ionesco put it perfectly when he told a Fleet Street reporter, "It is the *human* condition that directs the *social* condition—not vice versa."[12]

In the practice of our philanthropy we are missionaries of a sort—exacting, ambitious, and undauntedly determined to incite the agents of change to elevate the circumstances of existence for this astonishing hodgepodge of humankind arrayed within America's borders.

David Rogers' first President's Statement helps me appreciate how deeply this wisdom is embedded in RWJF's philanthropic DNA. His language jumps off the page as if intentionally composed to remind us today why it is we do what we do:

> "It is our hope that we can be effective, wise and compassionate in interacting with those in our society seeking to better the human condition.
>
> "We have, as an overriding belief, the conviction that human ingenuity, if given the chance, can invent practicable ways of moving toward the goals we have defined as our own–and giving that chance, in our judgment, is the appropriate and privileged role of a private philanthropic institution."

I find great comfort knowing that—regardless of the passage of time, the ebb and flow of crisis, and the surge and fade of threats real and perceived—the more all these things change, the more the heart and soul of our philanthropy remains the same.

Risa Lavizzo-Mourey, M.D., M.B.A.
President and Chief Executive Officer

Endnotes

1 Nixon's plan collapsed upon his resignation in 1974, beginning the spiral of distrust in government that commands so much attention today. For an excellent history of the presidential personalities and politics of health care reform, see *The Heart of Power* by physician David Blumenthal of Harvard Medical School and political scientist James A. Morone of Brown University. University of California Press, 2009.

2 Nixon to Congress, March 2, 1972: "The time now has come to take the final steps to reorganize, to revitalize and to redirect American health care—to build on its historic accomplishments, to close its gaps and to provide it with the incentives and sustenance to **move toward a more perfect mission of human compassion.**" *www.presidency.ucsb.edu/ws/index.php?pid=3757*

3 Dallek R, "Obama's Historic Health-Care Victory," *The Wall Street Journal,* Dec. 29, 2009, *http://online.wsj.com/article_email/SB10001424052748703278604574624123140468430-lMyQjAxMDA5MDMwMDEzNDAyWj.html.*

4 Calculations (35% in 2008 + combined 14.8% increase by 2019) from "National Health Expenditure Projections 2009–2019," Centers for Medicare & Medicaid Services, Feb. 3, 2010, *www.cms.gov/NationalHealthExpendData/downloads/proj2009.pdf.*

5 RWJF Commission to Build a Healthier America. *Beyond Health Care: New Directions to a Healthier America.* Princeton: Robert Wood Johnson Foundation, 2009, *www.rwjf.org/files/research/commission2009finalreport.pdf.* (The Commission study built upon the landmark research by McGinnis & Foege, reported in JAMA in 1993. See McGinnis JM, and Foege WH. "Actual Causes of Death in the United States." *Journal of the American Medical Association,* 270:2207–2212, 1993.

6 "Trends in Quality-Adjusted Life-Years Lost Contributed by Smoking and Obesity." *American Journal of Preventive Medicine,* February 2010, *www.ajpm-online.net/article/S0749-3797(09)00763-6/abstract.*

7 National Center for Health Statistics. *Obesity and Overweight,* 2008 data, *www.cdc.gov/nchs/fastats/overwt.htm.*

8 Thorpe KE. *The Future Costs of Obesity: National and State Estimates of the Impact of Obesity on Direct Health Care Expenses,* a collaborative report from United Health Foundation, the American Public Health Association and Partnership for Prevention, November 2009, *www.americashealthrankings.org/2009/report/Cost%20Obesity%20Report-final.pdf.*

9 ibid.

10 National Association of County & City Health Officials. *Local Health Department Job Losses and Program Cuts: Overview of Survey Findings from January/February 2010 Survey.* Washington: NACCHO, 2010, *www.naccho.org/advocacy/upload/JobLossSurvey_Overview-3-10.pdf.*

11 Recommendations from the RWJF Commission to Build a Healthier America, April 2009, *www.rwjf.org/pr/product.jsp?id=41008.*

12 *Observer,* June 29, 1958, as reported in *Notes and Conditions, pt. 2,* 1962.

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