President’s Message
From the 2005 Robert Wood Johnson Foundation Annual Report

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A TREE IN THE STORM:
Philanthropy and the Health of the Public

Even now, after so many painful months, I am haunted by memories of my visit early last fall to a makeshift shelter in what was left of Gulfport, Miss., in the aftermath of Hurricane Katrina.

The shelter was in a still-standing church hall near what once had been the boulevard along the beach. Row after row of canvas cots inches apart were the only home for about 125 people—parents and their children, the elderly, and the mentally ill. Many seemed overwhelmed by their struggles.

One old, old man lay curled on his cot, all alone at midday, sheets pulled over his head, seemingly lost and most likely forgotten. Was he a father? Maybe a grandfather? What had happened to him? To his home, his job? Was he wounded or sick or scared? Where was his family?

A few steps away a little girl sat pressed against the concrete corner wall clutching a pink comforter, a pile of stuffed animals and an old pillow pulled close around her. It might have been a snuggly corner of any American girl’s room. But it wasn’t.

No, this was a catastrophe’s wasteland and we were there as part of a group of foundation leaders being guided through the area by leaders of the American Red Cross.

Nothing I saw on TV or heard on the news prepared me for the reality on the ground. The rawness of the human and physical destruction literally took my breath away. Standing in the middle of a street that was more like a ragged path bulldozed through the rubble, I prayed that the odor of rotting flesh came only from dead fish and birds.

Even to this physician, it was disorienting and a little frightening. After all, here I was, representing the largest philanthropy in the world dedicated solely to improving the health and health care of our most vulnerable people, yet when faced up close with such immediate need I wasn’t even sure of my role or what I could do. Should I roll up my sleeves or roll out my checkbook?

THE BEST TIME TO PLANT A TREE IS TWENTY YEARS AGO.
THE SECOND BEST TIME IS NOW.
-African Proverb

Slow down, Risa, I told myself. Our job is to look and listen and learn. Remember that Katrina was about more than wind and water, rubble and ruin. This was a genuine cataclysm that shredded social, economic and health care infrastructures right along with the power and water systems. Hardest hit were the disadvantaged and disowned, many of them racial minorities, the very same people who were a priority for our philanthropy’s founder even before there was a foundation that bore his name.

What I needed was a snapshot of this post-Katrina landscape that I could take back to Princeton and apply to the bigger picture of what needs to be done to improve the practice of public health, the health of our communities, and the provision of health care in general.
My first primary indicator was the state of the health care available to Katrina’s survivors. Fortunately, despite the lack of water, sewers and power, the most serious medical and health problems had already been addressed. The injured and diseased were airlifted out early. Nurses and medics remained on-site.

Mental health professionals were the ones with the toughest jobs. Horrifyingly, some infants had been swept away in the storm surge. For their parents the grief was more catastrophic than the storm itself. One mental health worker told me that the stress of helping people deal with such tremendous loss was almost too much to bear.

Plenty of rescue and recovery teams, most from the private sector, were meeting other nonmedical needs. Local residents could sign up for food stamps and financial assistance over at the local movie theater. Scores of young people from all over the country were preparing food, giving people rides, doing the heavy physical lifting—and with great contagious spirit, too.

One Baptist church’s feeding station was dishing up 5,000 daily servings of meals like spaghetti, canned corn and Oreos. Pickup trucks and commandeered ambulances cruised beat-up neighborhoods, unloading styrofoam containers of hot meals and cases of bottled water.

So far, so good, I thought—but not for long.

Our little tour group stood out a bit too much. We were visitors from an outside world untouched by the disaster. Many of us were neatly dressed in business casual attire. Some wore shirts with relief agency logos. We looked cleaned up and official enough to draw lots of attention.

As we headed toward a meal tent for lunch, an elderly man with a handful of forms and papers approached asking, “Help me.” He’d just driven the 80 battered miles from New Orleans where he’d heard that relief agencies in Mississippi would give him food stamps and a check.

Someone in our party had to tell him he was on a wild goose chase, that financial assistance wasn’t available for him here and he had to make the drive back home—if he still had one.

We expected an angry reaction. Instead we saw resignation. Saying nothing, he lowered his head and simply walked away in a wordless act of dejection that has troubled me ever since.

That night, flying back north out of the Gulfport-Biloxi airport, I thought back to those two aged men, so late in their lives, and
to that little girl, so early in hers. They were living metaphors for a society that had failed to care for its own, and for human expectations that were dashed.

THEY TAUGHT ME TWO BIG LESSONS THAT DAY:
Lesson Number One – In America, most people presume that a certain level of publicly provided care and caring is available to them and they don’t worry particularly about who furnishes it or where it comes from. They take it for granted that government will secure their safety and protect their health when it needs to. But when that expectation is not met, many of our most defenseless people are so beaten down and so far beyond anger that they literally and figuratively pull the sheets over their heads and give up.

Lesson Number Two – Katrina exposed the unforgiving and long-avoided truth that mainstream America fails to regard huge numbers of our poorest, oldest, sickest, dispossessed, nonwhite people and their families as equal members of our society. If you have any doubt that we are defaulting to a two-tier society of haves and have-nots, just think of those amazing pictures of the lost and forgotten of New Orleans huddled on rooftops, waving crude signs that pleaded “Help Us,” and calling out for food and water that did not come. To me, this helps explain lesson number one.

These are harsh truths that we’ll be struggling with as a society for a long time and with great discomfort as the images of all that Katrina laid bare come into sharper focus and we realize that what we see for certain is ourselves.

It is not a pretty picture. This disaster forces us to come to terms with the depth and breadth of an entrenched inequality that spreads disadvantage and unfairness through every sector and segment of life in America, from housing and transportation to education and jobs, public safety and personal security, access to health care and the equality of the care delivered.

It especially hits home for us in public health because the mission of the Robert Wood Johnson Foundation is to improve the health and health care of all Americans.

We may not be able to fix the broken levees, restore ruined cities, house the homeless or feed the hungry. That’s not our job. But we most certainly can apply Katrina’s lessons to the wide range of good work that we support—to develop the quality of health care and strengthen the public health system.

This always has been a tough task because the traditional public health “system” is not really a system at all but a maze of thousands of local health agencies, hospitals, civic and faith-based groups, community and business organizations, a huge army of volunteers, state health and emergency management departments, the massive Centers for Disease Control, and,
since 9/11, a parallel and occasionally colliding universe of state and federal homeland security bureaucracies and budgets.

One might hope to make a coherent organization chart out of all these entities but even the dotted lines break apart because there is no sure way out of the maze. In fact, for most of the past 20 years political leaders and budget- and policy-makers at all levels failed to heed successively strong and explicit alerts that the whole multilayered contrivance is in bad shape.

The Institute of Medicine (IOM) repeatedly has warned us in blunt and unequivocal terms that this crazy-quilt system is “in disarray” and in need of a major overhaul. The IOM tells us that:

- The system is not “prepared to respond to new crises or emergent health problems.”
- The infrastructure is weakened by years of political neglect.
- Competent and professional leaders are in short supply.
- The workforce is insufficient and inadequately trained.
- Local and state laws are outdated and dysfunctional.
- Funding is second-rate and often comes with so many strings attached that it’s all but useless.
- Information systems and technologies are antiquated and vulnerable to failure and intrusion.
- Communications networks are ineffective and fragmented.
- Laboratories are obsolete and lack surge capacity.
- Disease surveillance and epidemiological systems lack integration and can’t deliver a real-time picture of imminent threat.
- Public and private sectors rarely collaborate over shared objectives.

This isn’t just an inventory of complaints. It is an indictment of how local, state and federal political leaders so dangerously neglected to protect the public’s health for so many years that the “system” became as badly compromised as the Mississippi Delta’s floodwalls and levees.

**How did America let such a vital line of domestic defense become so weakened?** I would suggest that public lack of awareness and chronic political disregard conspired over time to keep public health out of the public spotlight and off the decision-makers’ radar screens.

The result is a formula for certain failure: Local and state public health officials are expected to perform as superheroes in the face of rising threats, withheld resources, political mistreatment and too much uninformed second-guessing.

At the same time public health officials are accountable to a public that may not know they exist and to political leaders who ignore or overlook their repeated requests for critically needed funding and systems improvements.
For more than a decade the Foundation has concentrated on building up the public health infrastructure, modernizing the system's information technologies and developing a new, savvy cadre of leaders.

In pre-Katrina terms, progress has been good. Our more progressive partners have revamped outdated state and local public health laws. They are fighting—and winning—budget battles they previously lost. They are comfortable with high technology and information management systems. And they are remarkably better connected to key partners in the business, faith and civic arenas.

The one sector that still seems out of the loop is the public itself, even though every person in America has a stake in public health. It amazes me that in our age of hyperinformation most people can be so ill-informed about how the public health field protects and promotes their own good health and that of their families and neighbors.

I saw one survey in which more than nine out of 10 respondents could not come up with an answer when asked, “What do the words ‘public health’ mean to you?” Less than 4 percent knew about health education, preventing infectious diseases, immunizations, healthier lifestyles.

In another poll nearly 60 percent of registered voters didn’t have a clue how the so-called public health system “protects the population from disease” and “promotes healthy living conditions for everyone.”

Nevertheless, without hesitation the great majority said that funding public health was more important than building roads or cutting taxes. In other words, they may not know exactly what the public health services are or do, but they intuitively understand their importance.

Our own research helps explain why. The public’s responses tell us they believe health care is a social contract, a system that serves all of us through a shared set of such values as equality, compassion, mutual obligation, social responsibility and accountability.

Given this prevailing public belief, then, how is it that public health “gets no respect?”

**I SEE FOUR FACTORS AT WORK:**

**Factor Number One** – So much of what public health does flies below the radar screen until disaster strikes and that screen becomes all lit up. It’s only then that the cry goes up, “Too little, too late.”

Public concern and federal planning for a possible avian flu pandemic were all but nonexistent for nearly a decade. But after dozens died on the other side of the world and health...
experts warned that H5N1 was a “time bomb” waiting to go off in America, media critics suddenly started demanding, “What took you so long?”

It took years to overcome social inertia and special interest influence before the public acknowledged that childhood obesity has become an epidemic. As a result of this delay and denial we may be raising the first generation of Americans to live sicker and die sooner than their parents.

Factor Number Two – While the public health practice field is on task and well networked, in the political world it can be perceived as a disjointed, uncoordinated community that lacks a loyal and loud constituency. Because it is a wheel without a squeak the field gets hit hard when it comes time to cut budgets.

As the federal government expands the stockpile of vaccines and antibiotics for bioterrorism attacks and avian flu, the budget cuts support for the state and local agencies that are supposed to distribute the drugs. That makes no sense.

Take a look at the federal government’s Healthy People 2010 agenda. Preventing diabetes is Goal Number 5. With 800,000 new cases costing upward of $100 billion a year, this is an urgent public health priority, one that is tightly intertwined with the twin epidemics of childhood obesity and adult diabetes. Budget planners, however, stripped away hundreds of millions of dollars from the one U.S. Public Health Service program dedicated to preventing chronic diseases like diabetes. That doesn’t make sense either.

Factor Number Three – Most people mistakenly equate better public health with better individual health care. They fail to connect the dots that link their own health to prevention, environment, socio-economic status, risky behavior, geography and circumstances of birth.

For example, I recall a typical “better medicine” story last year that compared the competing benefits of heart-bypass surgery versus stents. Every major newspaper in the country ran it.

But where was the story about the deteriorating health status of a poor neighborhood with no nearby place to shop for meats, fresh fruit and vegetables, nonfat milk and low-fat snacks except at a convenience store where the prices are as much as 50 percent higher than at the suburban supermarket?

This is an important public health story that plays out every day in urban and, yes, even in suburban areas, where kids don’t
get proper physical exercise because gangs and drugs rule the playgrounds, it’s too dangerous to walk to school, and quality health care is neither accessible nor affordable.

Could it be that no one is telling this story because those hit hardest are people whom mainstream society forgets or shuns altogether? People who do the jobs no one else wants to do—the poor, minorities and immigrants, and people with stigmatized diseases like AIDS and TB, mental illnesses and addictions to alcohol and other drugs.

We need to do a better job practicing the wise old saying that to control a disease anywhere we must control it everywhere. I’d add this corollary: To improve health anywhere we must improve it everywhere. And for everyone.

**Factor Number Four** – Public health receives so little public and political respect because its success demands a level of government spending, laws, regulation and scrutiny of individual behavior that many Americans today are not willing to tolerate.

It is no accident that about 95 percent of all health spending goes for medical care and biomedical research, but no more than 2 percent for public health and disease prevention. This isn’t just counterintuitive, it is counter to the public’s safety.

Research tells us that risky behavior and social and physical environmental dangers cause more than 70 percent of avoidable deaths. This is where resources should be flowing. But correcting the 95-to-2 imbalance would require big shifts in how government allocates public resources and an earthshaking realignment of the private sector’s economic interests.

Public health leaders tell us that this is a tough sell if you try it on your own, especially if the public isn’t sure what you really do, your advocates are few and far between, and so many people are wary of government intrusion into their lives.

**Fortunately, we hold in our hands** the power to change the trajectory of these discouraging trends. The answer, as we see it, is in what philanthropy and public health can accomplish together.

RWJF is not new to this game. Back in the 1990s we abandoned our own 95-to-2 funding formula and realigned our public health strategies, and we have followed a 50-50 split between public health and health care investing ever since.

**NO MORE THAN 2 PERCENT OF ALL HEALTH SPENDING GOES FOR PUBLIC HEALTH AND DISEASE PREVENTION.**

Getting it right and keeping it right is a tall order. Our world today threatens us in ways as dreadful as the Black Death and as shocking as September 11th. Threats like avian flu are real, the needs they trigger are urgent, and they define the turbulent environment in which we are establishing our priorities and making our funding decisions.

Are we ready for what may be coming? We need to know so that we can decide what to do. In other words, “Show me the evidence!” And the evidence presents us with a classic case of the urgent overpowering the important.
On the one hand, the federal rush to build defenses against a would-be mass casualty bioterrorist attack is injecting the public health system with a big wave of new money, its first in decades. This is good.

But the intense national focus on bioterrorism preparedness at the expense of public health is shoving off the local table critical hometown health promotion and prevention issues such as diabetes, obesity, tuberculosis, sexually transmitted diseases, teen pregnancy prevention, and tobacco deterrence.

“Shifting federal priorities and programs are distracting from fixing fundamentals” was the judgment of Trust for America’s Health (TFAH), a major RWJF public health partner. Even though billions are being spent on biodefense, state and local health officials report that their communities actually are less prepared than before 9/11 to deal with sudden crises.

When we funded a study early last year by the Century Foundation Working Group on Bioterrorism Preparedness they found that:

- Many states “lack surge capacity”—the ability to triage and treat huge numbers of injured or ill adults and children in an emergency.

Then came Katrina. And, yes, states’ capacity quickly buckled as the crush of hurricane evacuees surged across the continent, ripping huge holes in the public health safety net.

Within days of the storm an unprecedented 45 states and the District of Columbia simultaneously were in federally recognized states of emergency.

Trust in national, state and local preparedness was swept away too. The epic calamity drastically undercut public confidence in our government’s capability to respond to any extreme situation. In one national poll, 70 percent of all adults said government at every level “did a poor job” in preparing for Katrina. And 49 percent expressed little or no confidence in the federal government’s ability to respond to natural disasters.

The public knows what it’s talking about. Late last year the 9/11 Commission gave the government woefully poor grades for its failure to take many of the steps the commissioners recommend are needed to protect the public from terrorist attack.

- 80 percent of local public health departments still cannot communicate instantly with state health departments, hospitals or local medical practices.

- Just as the 9/11 Commission found, first responder communications networks remain ineffective, incompatible and without sufficient wireless bandwidth.

- Regional planning among states is scarce and coordination with federal agencies almost nonexistent.

In one national poll, 70 percent of all adults said government at every level “did a poor job” in preparing for Katrina.

And the Trust for America’s Health reported that even with all the furor over pandemic flu our cities and states are nowhere near ready to respond adequately to public health catastrophes caused by disease, natural disaster or bioterrorism.

We are left, then, with this unanswered question: What will the government do to prepare for the next Big One and its fallout? Many fear that even now no one knows how to watch our backs.
This is where philanthropy comes in. The long-term goal of the Robert Wood Johnson Foundation is to help the country reverse its preparedness deficit, close the prevention gap, and restore the public's trust in the relevance and value of its own public health system.

We know how to successfully confront some of our most destructive specific health threats—such as smoking, substance abuse and recently, childhood obesity. But focusing on single threats or diseases is too narrow a focus to meet the greater challenges of these times.

We believe now more than ever that the key lies in how all sectors of a community rally to overturn an unacceptable status quo and work together in protecting the safety of their own residents and improving the overall health of the entire community.

It's called “connectedness” and it is at the heart of how public health must transform itself in the 21st century.

We’re talking here about disruptive and transforming social change, the kind that requires a solid historical, intellectual and even philosophical framework.

Several months ago I was invited to return as the Physician-in-Chief ProTem to Brigham & Women’s Hospital in Boston, the place where I served my residency and where I learned the true art and elegance of medicine. This was very much like going home; it stirred up fond memories of the world of teaching and learning that I've loved so much. Preparing what to say, I remembered being assigned to read The Structure of Scientific Revolutions by Thomas Kuhn, who taught philosophy and the history of science at MIT.

When I apply Kuhn's teachings to the hidebound status quo of today's health system, I can see that lasting and meaningful change requires a form of radical retooling that will occur only after a set of crises shatter tradition, nullify the status quo, force "raw and jagged paradigm shifts," and overturn one worldview for another.

In other words, we need nothing short of a revolution before we can retool. It has been done before. The Flexner Report on medical education in America nearly 100 years ago is one example. Unraveling the secrets of DNA would be another. Katrina is a crisis that is already feeding a revolution.

Kuhn came to mind again last year at a two-day retreat with leaders from philanthropy, business and health care. At the top of our agenda was a discussion of what would happen if we applied the business theory of “disruptive innovations” to health system reform.

Harvard Business School Professor Clayton Christensen not too long ago coined the term “disruptive innovations” to describe a level of change big enough and bold enough to transform business, markets, populations, even entire societies. It’s not an abstract concept. Think of how personal computers and diabetics’
home glucose monitoring, for example, have made a difference for millions of people around the world.

As I see it, Christensen's “disruptive innovation” offers a bridge between Kuhn's revolution and retooling. It's up to us to know when and how to cross it.

We know that as philanthropists we possess the vision, assets and staying power to retool. We also know from experience how to discover, test and leverage fresh “disruptive innovations” of our own. Examples include our work in improving the quality of care, transforming nursing care at the bedside, reinventing how we manage chronic medical conditions, or covering the uninsured.

This is philanthropy as it should be—summoning the forces of disruptive innovation and retooling to improve the health, health care and quality of life for everyone in America.

Real results, however, don't come from rhetoric. They come from what real people do in real time in the real world. The only way to see bona fide disruptive innovations at work in public health is to look to the field itself—because, just like in politics and health care, all serious change is local.

• In Nebraska the very idea of “public health” opposes the region's pioneer tradition of rugged individualism. But now advocates are showing the public the difference between providing medical services for individuals and protecting the health of the entire community. At the same time, the future of public health education in the state is being mapped out by a broad alliance of public and private colleges, health care providers, civic and consumer groups and professional associations. Public health serves “the whole community,” says the director of a new public health master's program at the University of Nebraska.

• In South Texas fiscal and political pressures are so powerful that they can even block immunization supplies from reaching certain schools. So now low-cost, high-yield community partnerships are stepping in where the government drops out. Aided by RWJF grants, local residents are trained in disease prevention and management, then dispatched to remote rural areas, isolated ranches and impoverished colonias of migrants along the northern edge of the Mexican border. They are called promotoras; the kids call them angelitos de salud—“health angels.” A Texas A&M promotoras trainer says, “They are the go-to people who always seem to know everything about everyone, and who know how to get things done.”

• In California, across the bay from San Francisco, the Alameda County public health department is pioneering “the new public health”—strengthening communities from within to take responsibility for their own health. Step One: Engage the whole community as the patient. Step Two: Show neighborhoods how interconnected they are. Small successes mean a lot. Rather than shut down 30 unlicensed street vendors, a public health nurse helped them form a cooperative, buy a closed-down restaurant, and prepare their food in compliance with health regulations. Business boomed and a poor neighborhood discovered that it could solve its own health problems.
In mid-Michigan’s auto belt, churches and community organizations are in a marathon to save the physical and mental health of their citizens in the face of relentlessly hard economic times. A partnership of 100 Flint churches takes physicians in training into poor city neighborhoods to learn from the experiences of low-income mothers. Church members knock on doors to gauge the prevalence and causes of infant mortality. A coalition of local business, labor, education, government, and health care groups provides cost-free coverage to 20,000 people who lack health insurance. Health advocates are winning a long campaign to ban smoking in workplaces. Restaurant owners compete to see who can maintain the most sanitary kitchens. One local leader boasts that it’s hard to tell where government ends and the community begins.

These are inspiring profiles in public health courage and leadership. The level of social connectedness in each of these communities is something many skeptics thought was a lost American quality. Quite the contrary. At RWJF we view it as a quality of life and good health multiplier. We see dedicated public health practitioners forging partnerships with local stakeholders to do together what neither could do on their own. Their efforts are bottom-up rather than top-down. They know how to translate family health information collected at an individual doorstep, into data that can benefit everyone in town.

I know these people and their programs and I’ve spent time out on the streets seeing for myself how they are, indeed, disruptive, innovative and literally in the act of retooling the future good health of communities where they live and work.

As one veteran community health organizer put it, people in communities like these “have come together with a common vision grounded in a commitment to systems of mutual support. That’s a rare thing in a self-focused society.” But it doesn’t have to be that way.

In the weeks and months since I returned from the Gulf Coast, I have been reminded just how much we need good news like this. And I’ve also found comfort in knowing that some good old news does not change, no matter what.

This past year marked the 100th anniversary of Jacobson v. Massachusetts, the landmark U.S. Supreme Court decision that
to this day defines the relationship between individual liberty and
the government’s obligation to protect the safety of its citizens.

Though they are a century old, the clashes and controversies
in Jacobson over vaccines, quarantines and civil liberties read as
if they were tomorrow’s headlines. And well they might be.

These are the facts: In 1905 an outbreak of smallpox threatened
the people of Cambridge, Mass. The city board of health said that
everyone needed to be vaccinated. Henning Jacobson, a Lutheran
minister, resisted, was arrested, convicted and fined $5. His appeal
went all the way to the Supreme Court.

Justice John Marshall Harlan, a firm defender of civil liberties
and civil rights, wrote the majority decision, ruling (to the surprise
of many) that mandatory vaccination was a justified limitation
on individual liberty during a deadly epidemic.

What resonates from the last century into this is Justice Harlan’s
prescient discussion of the “social compact” Americans still believe
in today. “Organized society,” he wrote, “could not exist without
safety to its members.”

This is a familiar theme to Americans. We thrive when we live,
as others have said, a life of “mutual helpfulness,” so that each
may “live well” in a society “held together by our need,” a society
that never forgets the character of its members.

Looking back, we can understand the collective anger, pain and
fear we experienced as a nation in those hard days after Katrina
when it seemed that our government somehow had failed to hold
up its end of that social compact.

I think of the old man alone and afraid on that cot in Gulfport and
of the little girl in the corner. I think of the other old man who drove
out of New Orleans seeking help and clinging to nothing more than
false promises and thin hope.

Our job as philanthropists is to be the disruptive innovator who
leads our partners in retooling our public health system so that it
delivers on its promises, meets the most healthful expectations
of our people and validates human hope.

And our task as social transformers is to strengthen the social
compact so that, like a strong tree in a storm, it may bend but
never break again. An old proverb from the Dayak peoples of
Borneo in Indonesia tells us that:

A firm tree does not fear the storm.

For the sake and honor of those we seek to serve, nor do we.

Respectfully submitted,

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President and Chief Executive Officer
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