

CHAPTER 1

The Robert Wood Johnson Foundation at Forty

David C. Colby, Stephen L. Isaacs, and Sarah G. Pickell

 In 1936, Robert Wood Johnson, the president and chairman of the board of Johnson & Johnson, established the Johnson New Brunswick Foundation to conduct his charitable giving in New Brunswick and Middlesex Counties, New Jersey. For the first three and a half decades of its existence, the foundation—which in 1952 became the Robert Wood Johnson Foundation—made nearly all of its donations to hospitals and other health care organizations, community-service programs, nursing, scholarships, and aid to the indigent.

Robert Wood Johnson died in 1968. After providing for family members, he left the bulk of his estate—shares in Johnson & Johnson (J&J)—to the foundation bearing his name. By the time the estate was settled three years later, the shares were valued at \$1.2 billion, making the Robert Wood Johnson Foundation the second richest foundation in the nation. In fact, the night after the new Foundation's endowment was reported in the newspapers,

burglars broke into the Foundation's offices on Livingston Avenue in New Brunswick looking to help themselves to the \$1.2 billion. They left empty-handed.

The Foundation's early trustees were, for the most part, current and past senior executives at J&J (a notable exception being William McChesney Martin, a former chairman of the Federal Reserve Board). Gustav Lienhard, the former J&J chief financial officer and chairman of the company's executive committee, chaired the Foundation Board with an iron hand until his retirement in 1985. Early on, the Board determined that in accordance with Robert Wood Johnson's interests, the new philanthropy would concentrate on advancing health and health care in the United States, and to press that agenda, it recruited David Rogers, the dean of the Johns Hopkins Medical School, as the Foundation's first president.

—w— **The David Rogers Era: 1972–1986**

A physician, teacher, and researcher, Rogers had challenged racial discrimination at Vanderbilt University when he was chief of medicine there, served the poor of Baltimore when he was at Johns Hopkins, and supported the passage of Medicare and Medicaid. "I came up to meet with the Board, and had a meeting with all or most of the trustees in the J&J headquarters," Rogers recalled in an interview. "After fifteen or twenty minutes, I realized this group was on a totally different, very conservative, wavelength. 'The thing that puzzles me,' I said, 'is why me? We disagree on virtually every social issue. You know, among my friends, I'm considered a liberal.' Philip Hofmann, who was then the J&J chairman and was on the Foundation Board, turned to me and said, 'We don't care what your politics are. We aim to make this the best foundation in the world, and we think you can do that.' And I thought, 'Okay, why not give it a try!'"¹

Rogers quickly brought on a first-rate staff, many of whom would go on to have stellar careers in their own right: for

example, Margaret Mahoney would head The Commonwealth Fund; Robert Blendon would become a leading health care survey researcher at Harvard University; Linda Aiken (whom Rogers recruited in 1974) would become a prominent nursing researcher and leader; Terrance Keenan would become a legendary grantmaker at the Robert Wood Johnson Foundation. As his special adviser, Rogers recruited Walsh McDermott, who had already won an Albert Lasker Award for his medical research. His role at the Foundation involved coaching Rogers and his staff, as well as providing counsel.

Rogers and his team established principles for the Foundation that still resonate forty years later. They agreed that the Foundation's grantmaking should be targeted—focusing on only a few selected areas of major concern. “We were going to be a rifle, not a shotgun,” Rogers said. They also decided to focus the Foundation's grantmaking on what Blendon called “investment activities,” that is, grants that would have a long-term payoff, as compared to short-term charitable grants.²

The idea of national programs developed early in the Rogers administration. With the guidance of experts in each particular area, the Foundation would design a program and outsource the selection of grantees, administration, and monitoring to a partner organization, usually headed by a leader in the field. If all went well, the federal government would pick up the funding of the program. As a side benefit, these national programs would also attract a network of influential people committed to the same goals. “What we did was get people involved who were a *Who's Who* in American health care,” Blendon recalled. “We got them very interested in the programs, and they became much more important advocates for changes and innovations than we could be.” By 1975, there were eight national programs.

To measure results, the Foundation commissioned outside researchers to assess large projects where the potential for measuring outcomes was great, and it hired an evaluation staff to oversee this work. To disseminate results, Rogers recruited a

communications staff and named Frank Karel as the Foundation's first vice president of communications, fulfilling Rogers's vision of "a top senior officer concerned with public affairs who will participate fully in the discussion of policy, the selection of areas of focus, and the considerations of proposals we plan to support."³ In this role, Karel pioneered the concept of strategic communications in philanthropy.

Programming: 1972–1980

The Foundation's initial challenge was to comply with the federal requirement to spend a percentage of its net assets amounting to roughly \$45 million the first year. "We picked some big programs we thought couldn't go wrong," Rogers said. "We put a big chunk into needy students in medicine, and bent it quite sharply toward minority students. We did several things like that, which didn't require a lot of research on the part of the Foundation."

Rogers and the staff then turned to the more substantial challenge of determining longer-term priorities. They sought the guidance of experts, holding a two-day meeting in March 1972 with leaders from medicine, economics, law, and government to discuss objectives for the new foundation. Then Rogers and Foundation vice president Blendon set to work mapping out a course of action. "David and I agreed pretty quickly that it was important to find a niche," Blendon recalled. "Access to care was what Rogers had been about. Then we added quality and public policy." In May 1972, Rogers presented the Board with the Foundation's three priorities—increasing access to medical services, improving the quality of care, and providing objective information on health care policy. The Board voted its approval.

Access to Care

"Although some segments of society had been particularly inadequately served, *no* group of that day was without problems in obtaining fully satisfactory, easily accessible health care...

especially for those who were ill but not in need of hospitalization,” Blendon, Aiken, and Rogers recalled.⁴ The challenge, they argued, was in providing “health services of the right kind at the right time to the right person.” To do this, the Foundation employed three strategies.

To serve the millions of people expected to be covered under the health reform proposed, but never enacted, during the Nixon Administration, the first strategy sought to expand the number and types of health professionals. The Foundation supported the training of medical students and residents committed to primary care and to serving in inner-city and rural areas. “Being the major foundation in health that was supporting primary care, we made generalist physicians kind of legitimate,” Rogers remembered. “At the time, everything was going in the other direction—to the subspecialties.”

But the Foundation did not rely solely on physicians to provide care; it launched programs to train nurse practitioners and physician assistants, at a time when both professions were in their infancy. The Foundation even funded a program to train health aides in Alaska to care for their neighbors in isolated rural communities. The dental profession was included as well, through both scholarships and training opportunities.

The second strategy was to demonstrate new approaches to providing health care services, with an eye cocked toward the federal government. “David Rogers and I always understood that the federal government was the buyer,” Blendon said. The nation’s hospitals were a logical place to start, and the Foundation quickly embarked on initiatives to encourage hospitals of all stripes (community, municipal, and teaching hospitals) to beef up their ambulatory care services.

Although the hospital programs were the main focus of the Foundation’s efforts to increase access to ambulatory care, probably the best known of the early demonstration programs is the one that helped create an emergency medical system. After the Department of Health, Education, and Welfare funded

five emergency medical services demonstration projects in 1972, the Robert Wood Johnson Foundation provided \$15 million to expand the concept to forty-four additional sites. Ultimately, the federal government picked up funding of emergency medical services, and the idea—which we now know as the 9–1–1 emergency phone number—spread throughout the country.

During this period, the Foundation also launched the School Health Services Program in four elementary schools, where nurse practitioners treated the students. Thus began the Foundation's long support of school-based health services, which expanded over the years, continuing through the early 2000s. It became, however, a controversial area. "Many people were pushing back," former Foundation vice president Peter Goodwin recalls. "The Foundation was seen as dispensing birth control in high schools. But it was really about basic primary care in schools."⁵ School health services are now available in approximately two thousand schools in forty-four states.

The third strategy the Foundation used to increase access to care was supporting research. In 1974, for example, the Foundation funded Ronald Andersen and Lu Ann Aday of the University of Chicago to conduct the first in a series of influential access-to-care surveys. "The access-to-care studies gave us a lot of legitimacy in the health policy community as a national research-based foundation," former Foundation vice president Aiken said. "It established the Foundation as a serious player."⁶ The Foundation also supported an important study by Robert Mendenhall and his colleagues at the University of Southern California School of Medicine which found that specialists were providing more primary care than had previously been thought.

Quality of Care

The second goal of this period was improving quality of health care, including prevention of illness by means such as better

nutrition and more physical activity. Forty years later, in the context of the childhood obesity epidemic, nutrition and physical activity have become even more important. Presciently, in 1972, the Foundation gave a grant to physician-researcher Lawrence Weed of the University of Vermont to support his work developing an early version of an electronic medical record.

Additionally, the Foundation adopted the Clinical Scholars program, which had been started by The Commonwealth Fund and the Carnegie Corporation of New York, and expanded it substantially. Under this program, physicians would study epidemiology or the social sciences in order to gain the breadth of knowledge needed to become leaders in the field. Among the more than 1,100 alumni of this signature Foundation program, which the health policy experts Rashi Fein and John Rowe termed “a national treasure,” are many of the nation’s most influential leaders in health services and health policy.

The Clinical Scholars Program provided the model for a program, launched in 1982, to develop leaders of the nursing profession. “The idea behind the Clinical Nurse Scholars Program,” said Aiken, “was to take people who already had their education and, through a postdoctoral experience, retool them in research and clinical care. The only way that nurses could get stature and authority in university settings was to be expert researchers.” Many of its sixty-two graduates went on to become leaders of the nursing profession.

Public Policy

The third goal was to improve the way health policy was formulated. To reach it, the Foundation helped build organizations—most notably the National Health Policy Forum at The George Washington University and the Institute for Health Policy Studies (now the Philip R. Lee Institute for Health Policy Studies) at the University of California, San Francisco—to provide high-quality information to policymakers.

With an eye toward developing the field of health services research, the Foundation supported researchers, many of whom, such as Karen Davis, Paul Ginsburg, Harold Luft, and William Hsiao, have become prominent in the field. It also created the Health Policy Fellows program, which gave, and continues to give, midcareer health professionals from academic centers the opportunity to work in a congressional or federal government office. This program has graduated more than two hundred fellows.

One little known program that had an important influence on public policy was the National Hospice Study. Launched in 1980 in collaboration with the federal government and the John A. Hartford Foundation, the study took place in the midst of a national debate on the treatment of terminally ill patients. The preliminary results were used to design a new Medicare hospice benefit that began in 1982. According to Aiken, the study “created a groundswell political movement that got the whole hospice movement off the ground.”

Programming: 1981–1986

Beginning in 1977, the Foundation began reviewing its priorities in light of the changing health care landscape. National health insurance had not materialized, and Robert Mendenhall’s research had revealed that although access to care remained a serious problem, the situation was better than had been previously thought. However, “the financing system in America was getting worse,” Blendon recalled. “More people were uninsured. The government was not funding inner-city programs . . . we were in a situation where, rather than being ahead of the wave, we were out there by ourselves.”

The review led the Foundation’s leadership, in 1980, to refocus its work. It established three priorities: First, it would continue its work to improve access to health services, but focus that work on the underserved. Second, in an attempt to address

the issue of rising medical costs, it would strive to make health care more effective and affordable. Third, it would aim to improve services for people with chronic conditions. In addition, the Foundation agreed to commit funds to improve diversity in the health professions.

Access to Care

Between 1981 and 1986, the Foundation allocated about a third of its grant dollars to improving access for particularly vulnerable populations. These included homeless people. The Health Care for the Homeless Program, funded in collaboration with The Pew Charitable Trusts, provided health and social services to homeless people in eighteen states and became the model for the federal McKinney Homeless Assistance Act of 1987.

Children born into difficult circumstances comprised another vulnerable population. Largely under the leadership of Ruby Hearn, at the time a Foundation program officer (she later became a vice president and then the senior vice president), the Foundation launched many programs aimed at improving children's health. These included programs to send registered nurses into the homes of poor pregnant single women to teach them how to care for themselves during their pregnancy and how to care for their children after they are born,⁷ to develop networks of perinatal care hospitals in rural areas,⁸ and to continue bringing health care into the nation's elementary and secondary schools.⁹

Effectiveness and Affordability

In the early 1980s, the rising cost of health care emerged as an important concern, and the Foundation responded by funding a variety of demonstration programs and research projects testing different ways of reining in costs. The Foundation's primary effort was the Community Programs for Affordable Health Care, to determine whether community-based groups could contain

health care costs. An evaluation found that the effort did not succeed because communities simply did not have the power to lower the cost of health care. None of the Foundation-funded programs succeeded in finding lasting ways to reduce costs, and this priority was soon abandoned.

Chronic Conditions

In his 1981 president's message, David Rogers noted that more than thirty million Americans had "health-related functional limitations that interfere with their effectiveness." That same year, the Foundation funded several programs to address issues of chronic illness. Perhaps the most successful, in terms of results and longevity, was On Lok, a San Francisco-based program that provided integrated acute and long-term care for low-income, nursing-home-eligible seniors, enabling them to remain in their homes. With the inclusion of the Program for All-Inclusive Care for the Elderly in the Balanced Budget Act of 1997, the federal government adopted the On Lok approach as one available for people eligible for both Medicare and Medicaid. State governments, however, have been cautious in adopting the approach.

By 1986, AIDS had become the nation's most visible health problem. "It was very controversial within the Foundation," says the former Foundation vice president Paul Jellinek. "Even so, it was too important for the nation's largest health foundation to ignore. So David Rogers asked Drew Altman, who was then a Foundation vice president, and me to go to San Francisco and check out an apparently effective program that was providing care in the community to people with AIDS." Subsequently, the Foundation authorized the AIDS Health Services Program to replicate the San Francisco approach in eleven other cities. When Congress passed the Ryan White Act (the vehicle through which federal AIDS prevention and treatment programs are funded) in 1990, it adopted the Foundation's community-based approach.

In recognition of the Foundation's work, Rogers was named the vice chairman of the National Commission on AIDS after his retirement from the Foundation.

Diversity

In addition to the fellowship programs begun earlier in the Rogers era to train physicians, nurses, and dentists, the Foundation sought to attract minorities to the health professions and to bolster their chances of succeeding. In 1983, the Foundation began the Minority Medical Faculty Development Program (now named after Harold Amos, the first African American to chair a department at the Harvard Medical School) to increase the number of minority faculty members at nonminority medical schools, even as it supported faculty development at the nation's historically black medical colleges. The commitment to minorities in the health field has characterized the Foundation ever since.

Looking Back at the Rogers Years

"It was Rogers' vision that made the Foundation," Aiken said. "He had a notion that the Foundation was going to be like a quasi-university . . . a place where intellectuals, but intellectuals who knew how to do something, would come together and take advantage of the incredible opportunity of having money to test ideas." In the Rogers era, the DNA of the Robert Wood Johnson Foundation was created. In program terms, it can be simply stated: research a problem; build a national program to address it; evaluate the solutions; and communicate the results in the hopes that the federal government would adopt and finance the idea. In other words, at a time when government was viewed positively, the Foundation saw its role as the research and development arm of the health care field. In some cases, such as health care for homeless people, AIDS services, and the On Lok model of community care for seniors, the government did pick up programs piloted by

the Foundation. In other cases, such as nurse practitioners and physician assistants, the fields became part of the mainstream, facilitated by market forces and government support.

Part of the Foundation's DNA had to do with developing leaders through programs such as Clinical Scholars and providing the opportunity for minorities to become health professionals, another enduring commitment. Still another legacy from those years is the Foundation's emphasis on research, evaluation, and communications. Perhaps most significant, during the Rogers era, the Foundation became strategic and mission-driven—addressing long-term solutions for a limited number of health care issues affecting the most vulnerable segments of American society.

—∞— **The Leighton Cluff Era: 1986–1990**

When David Rogers retired in 1986, the Board, now chaired by attorney Robert Myers, named as his successor Leighton Cluff, who had chaired the Department of Medicine at the University of Florida before becoming the Foundation's executive vice president in 1976. Both Cluff and Myers viewed themselves as short-term appointments. "I had not intended to be the president very long because I wanted to retire," Cluff said. "It had become clear to me that Bob Myers also looked upon himself as a person who was not going to stay very long."¹⁰

For Cluff, the health care environment required the Foundation to become more flexible and responsive. He was willing to let a thousand flowers bloom in the hope of growing one that was gorgeous. The saying, "Before you find a prince you have to kiss a lot of frogs," was framed on his office wall. Moreover, the Foundation staff "was beginning to recognize that many of the health problems they needed to address were inextricably intertwined with social problems," according to Alan Cohen, the vice president for research and evaluation under Cluff.¹¹ This, too, was a change from the Rogers era, when health care was the predominant, almost singular, focus.

Cluff significantly broadened the way that communications were used. During his tenure, the Foundation gave its first grant to support news coverage—to WGBH in 1988 for *The AIDS Quarterly*, hosted by news anchor Peter Jennings. The award-winning program was later expanded into *The Health Quarterly*. The Foundation, also for the first time, funded a targeted public relations effort by supporting, beginning in 1989, the media campaigns of the Partnership for a Drug-Free America.

Although Cluff strongly supported evaluation, Cohen changed the focus somewhat, emphasizing formative evaluation because, he said, “It was important to us to feed information back that could strengthen the program.”

Although Cluff had been considered a disciple of Rogers, under his administration programming took a different turn. He wanted to open up the Foundation to new areas and new—mainly community-based—grantees. In keeping with this philosophy, Cluff broadened the Foundation’s grantmaking priorities from three to ten.¹² Interestingly, the priorities did not include access to care. “That traditional focus of Foundation support was diminished, in order to direct energies and resources on those populations most likely to be overlooked in a generally improved (albeit still imperfect) health care delivery system,” Cluff said.¹³ As expected under this approach to grantmaking, some areas were effective and long-lived while many fell by the wayside. The following are among the highlights of the Cluff era’s programs.

Research into the Organization, Financing, and Delivery of Health Care Services

Through the Changes in Health Care Financing and Organization (HCFO) initiative, the Foundation helped strengthen the field of health services research, nurtured many of the field’s leading researchers, and provided information upon which policies could be based. The initiative remains active today. The Foundation also funded research into many of the pressing issues of the time.

For example, a major study that looked at medical malpractice reached conclusions that continue to be cited today, and the largely negative findings from the Health Care for the Uninsured Program, designed to find ways for small employers to insure their employees, remain pertinent.

Mental Health

In the mid-1980s, the Foundation launched two programs to improve the disorganized systems of delivering mental health services. The first, the Program on Chronic Mental Illness, which was carried out in collaboration with the U.S. Department of Housing and Urban Development in nine cities, sought to centralize responsibility for mental health services in a single agency. The second, the Mental Health Services Program for Youth, encouraged state and local partnerships to coordinate care for children with mental health problems; the \$19 million provided by the Foundation was the largest single influx of money into the children's mental health system up to that time. Both programs provided models for better coordination of mental health services and underscored the importance of improving the quality of mental health services, in addition to the systems by which they are delivered.

Long-Term Care

In the late 1980s, the issue of older people impoverishing themselves in order to qualify for Medicaid coverage of nursing-home care received national attention. To address this issue, the Foundation developed, in 1987, a program to test a new way of financing long-term care. Under the Program to Promote Long-Term Care Insurance for the Elderly, private insurance companies and governments of four states entered into partnerships whereby seniors who purchased private long-term care insurance policies would not have to spend down their resources to receive Medicaid.

Although the results were disappointing (people bought far fewer policies than the originators had expected, and buyers tended to have higher incomes than had been envisioned), the model proved attractive to Congress which, in the Deficit Reduction Act of 2005, allowed Medicaid programs in all states to adopt long-term care insurance partnerships.

To allow people with dementia to live at home, the Foundation funded two programs that examined the potential of adult day-care centers.¹⁴ These programs showed that such centers could effectively serve people with chronic illness and provide respite to caregivers.

AIDS

Cluff continued the Foundation's work to combat AIDS that had begun toward the end of the Rogers era, but expanded the approach to prevention—not just treatment—of the disease. The AIDS Prevention and Services Project sought to attract a broad set of community-based grantees by simplifying the application process, providing a telephone hotline to help applicants, and asking potential applicants for proposals that would organize prevention services as they saw appropriate. “It was an unprecedented undertaking for the Foundation to do both an open-ended call for proposals and for it to be on AIDS,” recalled the former senior vice president Ruby Hearn. “More than one thousand organizations applied—many of them community groups. This was an overwhelming response.”

Substance Abuse

In the late 1980s, the nation found itself in the throes of a drug epidemic that many people felt threatened the very fabric of society. The Foundation developed a three-pronged approach to addressing it. The first prong was a program called Fighting Back, which started in 1988 and continued until 2003. It was an \$88 million program to assist community-led coalitions to implement

a variety of anti-drug and anti-alcohol abuse strategies. Shortly after it began, the federal government adopted the model and expanded it to 251 sites. The second prong, a companion program, Join Together, which remains active today even after Foundation funding has ended, provided technical assistance to community coalitions and information for the field and for policymakers. The third prong, Community Anti-Drug Coalitions of America, addressed, and continues to address, policy issues directly on behalf of its community-coalition members.

End-of-Life Care

Toward the end of Cluff's tenure, the Foundation launched a major research study into the care given to hospitalized, terminally ill patients. The findings from the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments, or SUPPORT as it was called, did not become available until 1995. When the negative results were released, they led the Foundation to embark on a widely praised effort to reform the care of dying patients.

Looking Back at the Cluff Years

Because the Cluff era was a relatively short, transitional one, it is difficult to judge whether his approach to philanthropy—experimenting with many different priorities and approaches in the hopes of finding some that work—would have succeeded. Moreover, it was a political period—the Reagan-Bush years—when the federal government was less likely to pick up successful programs than it had been under previous administrations. Perhaps the most noteworthy feature of the Cluff era was its recognition that people's health depended on more than increased access to medical services—that it depended on social and behavioral considerations as well. As the Foundation's oral historian, Joel Gardner, observed, "By making substance abuse a priority,

Cluff set the stage for the Foundation's later work to combat smoking. And his efforts to engage the issue of AIDS, along with social and behavioral health problems, presaged the Foundation's later reorganization into health and health care components."¹⁵ Finally, the Foundation's use of communications as an intervention itself, through the *AIDS Quarterly* television show, led to an expansion of the Foundation's approach to communications in later years.

—∞— **The Steven Schroeder Era: 1990–2002**

Sidney Wentz, the former chairman and CEO of the insurance company Crum & Forster, replaced Robert Myers as the Foundation's Board chairman in 1989. The following year, the Board named Steven Schroeder, a general internist and professor at the University of California, San Francisco, as the Foundation's third president.

Schroeder quickly sharpened the Foundation's focus to three strategic priorities: expanding access to care, improving chronic illness care, and reducing the harm caused by substance abuse, especially smoking. He presented this agenda to the Board at a retreat in February 1991. "Most of the debate focused on substance abuse and whether or not cigarettes and alcohol should be in," Schroeder recalled. "The debate got very heated."¹⁶ Board members worried that the reputation of the Robert Wood Johnson Foundation would be sullied by getting into conflict with the tobacco companies. "Ultimately, we had a vote whether we should go with substance abuse, and it was eight to eight. At that point, we evolved a compromise that we would keep alcohol and tobacco in but focus on youth only."

Containing the cost of medical care emerged as a mini-priority but was quickly abandoned as beyond the reach of the Foundation to influence, just as it had been abandoned earlier.

The extraordinary growth of the Foundation's endowment during the boom years of the 1990s (assets tripled from roughly

\$3 billion in 1990 to nearly \$9 billion in 1998) stimulated a discussion of how the money should be spent and how the Foundation should be organized. Initially, Schroeder proposed using some of the endowment to establish a separate foundation concentrating only on substance abuse. The Board nixed that idea. But in 1997, it approved a reorganization of the Foundation into two groups: one devoted to health care (headed initially by Jack Ebeler and, after April 2001, by Risa Lavizzo-Mourey) and the other to health (headed by J. Michael McGinnis). “I wanted to see if we could institutionalize the health part,” Schroeder said.

During Schroeder’s tenure, communications—led by Frank Karel and, upon his retirement at the end of 2001, by David Morse—became increasingly used as a strategic tool, as seen by the annual Cover the Uninsured Week, the advocacy work of the Center for Tobacco-Free Kids, and the coalition building of the Last Acts program. With the recruitment of a new vice president, James Knickman, the Foundation made evaluation more relevant to program staff and conducted research into areas of interest to policymakers. It measured performance toward reaching its program goals quantitatively and through an annual “scorecard” that measured not just results for program areas but also for the Foundation’s own management performance and reputation in the field. The communications and research and evaluation units collaborated in developing Grant Results Reports, now known as Program Results Reports, and the *Anthology* series to examine programs and clusters of programs, and to share the findings widely.

Although it is difficult to prove the value of fellowship programs quantitatively, Schroeder—and his two executive vice presidents, Richard Reynolds through 1996 and Lewis Sandy between 1997 and 2002—believed in their value. Not only did Schroeder expand the Foundation’s ongoing Clinical Scholars and Health Policy Fellows programs, he also added new ones to strengthen research and to attract more minorities to the health professions. Schroeder also revitalized the Local Initiative Funding Partners Program (now known as the Robert Wood Johnson

Foundation Local Funding Partnerships program), under which the Foundation collaborated with local foundations to expand promising community-level programs.

Programmatically, the Schroeder era is perhaps best characterized by the Foundation's programs to reduce smoking (and, to a lesser extent, substance abuse), improve end-of-life care, expand health insurance coverage, improve chronic care, and advance primary care.

Tobacco Control

Between 1991 and 2002, under the leadership of Schroeder and Nancy Kaufman, whom Schroeder brought on as a vice president to oversee the Foundation's tobacco control and other substance abuse programs, the Foundation invested more than \$700 million in a wide-ranging effort to reduce tobacco use. As it evolved over the decade, the Foundation's approach contained four elements: research, advocacy and policy, coalition building, and smoking cessation.

Research

Through its Tobacco Policy Research and Evaluation Program and its successor, the Substance Abuse Policy Research Program, the Foundation created a field of tobacco-policy research whose findings influenced policy throughout the country. Frank Chaloupka at the University of Illinois at Chicago, for example, documented that increasing the tax on a pack of cigarettes would reduce sales—especially to young people—and provided the rationale for increasing excise taxes on cigarettes. John Slade, a professor at the University of Medicine & Dentistry of New Jersey, analyzed the tobacco industry and public documents, leading to a better understanding of the addictive nature of nicotine—which in turn provided the underpinning for the U.S. Food and Drug Administration's being given authority to regulate tobacco products in 2009.

Advocacy and Policy

In 1996, the Foundation established the National Center for Tobacco-Free Kids (now known as the Campaign for Tobacco-Free Kids) to serve as the voice of tobacco control and a counterweight to the tobacco industry. The center quickly established a national network of thousands of grassroots advocates, spokespersons, and alliances dedicated to reducing children's tobacco use. Nationally, it played a leading role in negotiating a settlement of a lawsuit brought by state attorneys general to require the major tobacco companies to reimburse state governments for Medicaid costs expended on persons treated for tobacco-related diseases.

Coalition Building

The third element in the Foundation's strategy—organizing and financing local and state coalitions to be advocates for tobacco-control policies—fell primarily to the American Medical Association in its role as the national program office for the SmokeLess States Program. From 1993 to 2004, the work of SmokeLess States coalitions contributed to increased tobacco taxes in thirty-five states, clean indoor-air legislation in ten states, and ordinances to restrict young people's access to tobacco products in thirteen states.¹⁷

Helping Smokers Quit

The Foundation's staff and its grantees sought to translate research findings into practical smoking-cessation guidelines (such guidelines were adopted by both the U.S. Public Health Service and the National Committee for Quality Assurance) and programs that could be adopted by employers and covered by insurance.

In 2011, the Foundation released an independent analysis of its tobacco-control work. Even recognizing the difficulty of

attributing behavioral change on a national level to any single player, the analysis concluded that “The Robert Wood Johnson Foundation’s contributions were significant.”¹⁸

Alcohol and Illicit Drugs

At a time when few foundations were interested in alcohol and illicit substance addiction, the Robert Wood Johnson Foundation made combatting it a priority and funded both research studies and demonstration projects. The College Alcohol Studies, a series of surveys on drinking by college students, conducted by the Harvard University researcher Henry Wechsler between 1992 and 2006, alerted the nation to binge drinking on the nation’s campuses. Research conducted under the auspices of the Substance Abuse Policy Research Program revealed, among other things, that office-based methadone treatment was effective and that lives can be saved by automobile ignition devices that prevent a car from starting if a driver is drunk. Research by the National Center on Addiction and Substance Abuse, and its promotion by the center’s president, former Health, Education, and Welfare Secretary Joseph Califano, received considerable media coverage and heightened awareness of the extent and consequences of substance abuse. The Bridging the Gap program became a major source of data on adolescent smoking, drinking, and illicit drug use.

Demonstration programs were mounted to test the effectiveness of community anti-substance-abuse coalitions;¹⁹ to support community development efforts through community coalitions working with local Head Start organizations;²⁰ and to improve systems of treating young people with substance-abuse addictions who are in the juvenile justice system.²¹ Spurred by the College Alcohol Studies, the Foundation developed programs to reduce binge drinking on college campuses²² and to prevent the sale of alcohol to high school students.²³

By the late 1990s, new knowledge—especially about the neurobiology of addiction—had demonstrated the possibility of treating addiction with medication. But there was still little financing for treatment, and the available care was often not only of low quality but was delivered in a fragmented system. In the last year of the Schroeder era, 2002, the Foundation funded two new programs aimed at improving access to, and the quality of, addiction treatment.²⁴

To build public awareness, the Foundation sponsored, in 1998, a five-part PBS television series on addiction and recovery, hosted by Bill Moyers. It also funded the Entertainment Industries Council's PRISM Awards to those in the entertainment industry who most accurately depicted tobacco, alcohol, and drug abuse.

An assessment of the Foundation's drug abuse programs published in Volume XIII of the *Anthology* concluded, "On balance, the Foundation's sizable investment in addiction prevention and treatment was considered a qualified success, weakened by a lack of a strong, steady strategic vision, episodic program decisions, and some institutional infighting. And looming constantly over the fragmented drug addiction work was the Foundation's signature accomplishment: its highly regarded efforts to reduce smoking. It proved to be a very tough act to follow."²⁵

End-of-Life/Palliative Care

When the results of SUPPORT, the large research study designed to test ways to improve the care of dying patients, were released in 1995, they were devastating. Despite specially trained nurses who counseled terminally ill hospitalized patients and their families about their options, patients were still not receiving the kind of care they wanted and, contrary to their wishes, were tethered to machines. In response to this discouraging news, the Foundation developed a multiyear, multicomponent initiative to improve the care of dying patients.

The first component was to increase the knowledge and capacity of health care professionals in caring for dying patients. The Foundation funded the development of training programs for physicians and nurses, encouraged publishers to incorporate material on end-of-life care in medical and nursing textbooks, and supported a regular series in the *Journal of the American Medical Association* to bring end-of-life care to the attention of physicians.

The second component was to improve palliative care²⁶ in hospitals and other health care institutions. To this end, with support from the Foundation, the Center to Advance Palliative Care at New York City's Mount Sinai Medical Center became a national resource for research, information, technical assistance, and training on palliative care. Palliative care has grown rapidly. It is now offered in most major hospitals and is recognized as a subspecialty by the American Board of Medical Specialties.

The third component was to modify state regulations on pain management so that physicians could prescribe, without fear of prosecution, controlled substances to patients suffering great pain. Thanks in part to Foundation-funded work by the University of Wisconsin School of Medicine and Public Health—which provided information and assistance to state attorneys general and other government officials—thirty-five states modified their pain-management policies between 2000 and 2007.

The Foundation supplemented these efforts with an aggressive outreach and communications effort that developed community coalitions through the Last Acts program; publications, such as the *Five Wishes* booklet, that publicized living wills, health care proxies, and durable powers of attorney; and a four-part PBS series on death and dying in America, *On Our Own Terms*, hosted by Bill Moyers, which was watched by more viewers than any other program in U.S. public television history up to that time.

An independent retrospective analysis of the Foundation's end-of-life programs concluded, "The achievements are remarkable . . . the impact is being felt in the actual practice of medicine."²⁷

Access to Care

Given Schroeder's earlier work to promote primary care, it is not surprising that soon after his arrival the Foundation launched a series of programs to increase the supply of generalist physicians—general internists, general pediatricians, and family practitioners.²⁸ For a brief period in the mid-1990s—when it appeared that primary care would take off under managed care—academic medicine appeared receptive to generalist medicine. But as managed-care expansion slowed in the late-1990s following a consumer backlash, medical schools reverted to their historical preferences for specialists and basic research.

While the generalist physician programs concentrated on increasing the *supply* of primary-care doctors, other programs focused on their *distribution* and included health professionals other than doctors. The Foundation employed a variety of approaches: testing different ways to recruit primary-care providers to underserved areas;²⁹ encouraging physicians to volunteer their services to uninsured people;³⁰ using distance-learning techniques to train nurse practitioners, nurse-midwives, and physician assistants in their own homes, often in rural areas;³¹ and offering incentives to attract health professionals to work in the rural South, where people had less access to care than anywhere else in the nation.³²

When President Clinton announced, in early 1993, the establishment of a task force to develop a plan to provide health insurance coverage for all Americans, the Foundation, which had long been waiting for such a moment, turned its attention to health reform. It made the considerable body of Foundation-funded research on health insurance and coverage easily available to policymakers. More visibly, it organized four *Conversations on Health*—widely publicized meetings designed to raise public awareness about the importance of expanding insurance coverage. Schroeder chaired three of the four meetings. “We made a very serious effort to keep the forums evenhanded, inviting

Republicans as well as Democrats to attend,” former Board chairman Wentz recalled. “But it turned out that mostly Democrats attended.”³³ The Foundation received withering Republican criticism for engaging in partisan politics. In retrospect, according to Brown University political scientist James Morone, the Foundation appears to have unwittingly gotten caught in the crossfire of internal Republican politics.³⁴

After the defeat of the Clinton health-reform plan and stung by the accusations of partisanship, the Foundation turned its attention to the states while simultaneously monitoring the changes taking place in the health care system and trying to keep the idea of national health reform alive.

At the state and local levels, the Foundation funded experiments to expand health insurance coverage,³⁵ giving particular attention to insuring children. Through its Covering Kids & Families Initiative, the Foundation gave states support in conducting outreach, simplifying the enrollment and renewal processes, and coordinating enrollment of children eligible for Medicaid or the State Children’s Health Insurance Program. The initiative was supplemented by a large-scale communications effort built around annual Back to School campaigns, which grassroots activists used to enroll needy kids in health insurance programs. Between 1997 and 2002, a time when the number of uninsured adults was rising, the number of uninsured children dropped from 11 to 8 million.

To monitor the changes occurring in health care, especially the rise of managed care, the Foundation created the Center for Studying Health System Change in 1995. The Center, which now receives support from many sources, has become an influential source of information for government policymakers. The Foundation also continued funding research on health insurance and access to care by the Urban Institute and the Economic Research Initiative on the Uninsured at the University of Michigan.

To keep the issue of health insurance coverage alive, even after it had dropped off the national policy agenda with the failure of health reform in 1994, the Foundation funded six

reports by the Institute of Medicine between 2000 and 2004 on the uninsured and the consequences of being without health insurance. The reports generated widespread national attention, as did the Foundation-funded “strange bedfellows” group. The group brought together an unlikely coalition of labor, business, insurers, hospitals, nurses, physicians, and consumer advocates to see if they could find common ground. In fact, they were able to do so, and in 2000 the group issued a statement highlighting that most of the uninsured were working Americans and that the consequences of not being insured could be devastating. The work of the strange bedfellows led to the Cover the Uninsured Week campaigns between 2003 and 2010, featuring radio, television, print advertising, and grassroots organizing to underscore the importance of having health insurance. Other organizations provided financial or in-kind support to the campaigns.

Chronic Illness Care

In the 1990s, as it became clear that chronic conditions such as asthma, diabetes, and depression were dominating health in the United States—accounting for more than three-quarters of the nation’s health care expenditures—the Foundation developed a number of initiatives focused on improving the care of people with chronic illnesses. It approached the subject along three tracks.

The first consisted of programs to improve the way chronic care is delivered—particularly by managed care organizations, which in the 1990s were beginning to play a more important role in the health care landscape. Perhaps the most significant of these programs was “the chronic care model” pioneered by Edward Wagner, a physician with the Group Health Cooperative, a Seattle-based HMO. Wagner’s model, which relies on teams of health care professionals working with patients to manage and monitor their chronic illnesses, has been widely adopted by HMOs throughout the country. The Foundation also tested,

through a program called Cash & Counseling, the concept of giving homebound seniors the authority to control the way in which money was spent on their own personal care, even to the extent of paying family members rather than agencies.³⁶ Congress subsequently passed legislation permitting states to adopt this approach as an option within Medicaid.

The second chronic-care track supported initiatives to improve the *quality* of the care provided to people with chronic illnesses.³⁷ *The Dartmouth Atlas of Health Care*, which compares the quality and cost of care—especially chronic care—in different locales, has been particularly influential, as has research by Elizabeth McGlynn and her colleagues at RAND that found patients received recommended care only 55 percent of the time.³⁸ The Foundation funded two groups—the National Committee for Quality Assurance and the National Quality Forum—that set quality-of-care standards, particularly for chronic care, and certify health care organizations based on their compliance with the standards. Moreover, the Foundation tested ways that health care systems could adopt management practices from Toyota and other famously efficient companies, hospitals could reduce medical errors, and providers' pay could be linked with their performance.

The third track focused on improving care for individuals with such specific chronic illnesses as asthma, depression, and diabetes. The projects funded under these initiatives tended to focus on improving the systems of delivering care for these specific conditions.³⁹

In addition to the three tracks, which tended to focus on improving systems of care for chronically ill people, the Foundation developed a large (\$90 million) program, Faith in Action, that supported interfaith coalitions whose volunteers would deliver services to their homebound neighbors. At one point, more than a thousand interfaith coalitions were participating.

Looking Back at the Schroeder Years

When Schroeder arrived, he quickly refocused the Foundation on a limited number of objectives—tobacco and substance abuse, chronic care, and access to care. His longest lasting program legacy will probably be the Foundation’s work to reduce smoking, followed closely by its work to bring palliative care into the medical mainstream. In both tobacco control and palliative care, the Foundation focused on policy change and used all of the tools available to philanthropy—research, advocacy, communications, evaluation, training, and convening—to reach its goals.

After the failure of the Clinton plan in 1994, national health reform dropped from the policy agenda. This, combined with the severe criticism of the Foundation for its suspected partisanship, led the Foundation to concentrate largely on state-level reforms and policy research during the rest of the decade. In terms of its chronic care priority, the Foundation did not enjoy great successes in the 1990s, but it kept a moral stake in the ground at a time when major change was unlikely. Many grantees funded by the Foundation in the 1990s—Dartmouth, the quality ratings agencies, and the Institute for Healthcare Improvement, for example—are now the leaders in the “quality movement” that has gained increasing importance in the 2000s.

Perhaps the most significant legacy of the Schroeder era was giving *health* an equal status with *health care*. During the Rogers presidency, the Foundation had focused almost exclusively on health care. In the Cluff era, there was some recognition of factors influencing health other than health care. With the research of J. Michael McGinnis and William Foege in the early 1990s showing that behavior and class had a more significant impact on health than medical care,⁴⁰ an increased emphasis on health made eminent good sense. But it was not an easy sell in a Foundation whose Board and staff were accustomed to viewing their role as improving health care.

Finally, Schroeder made a conscious effort to increase the Board’s diversity and make it a truly national one. When he

became the president in 1990, the Board was comprised of white males, nearly all of whom lived in New Jersey. When Schroeder left, the Board had members from around the country, and included an African American and a Latina. Four of the seventeen trustees were women.

—∞— **The Risa Lavizzo-Mourey Era: 2003–Present**

When Schroeder retired at the end of 2002, the Board, now chaired by former J&J vice chairman Robert Campbell (Tom Kean became the chairman in 2005), promoted Risa Lavizzo-Mourey from senior vice president for health care to president and chief executive officer.

A geriatrician by training and a health policy expert by experience, Lavizzo-Mourey, who had come to the Foundation from the University of Pennsylvania, retained the overall organizational structure of the Foundation, naming James Marks as the vice president for health and John Lumpkin to succeed her as the vice president for health care. She organized the Foundation's work around teams (currently, there are seven teams: human capital, vulnerable populations, coverage, quality/equality, public health, childhood obesity, and pioneer) that were charged with carrying out the strategic priorities established in a new Impact Framework. Lavizzo-Mourey made a public commitment of \$500 million to reduce childhood obesity by 2015, and she has placed considerable emphasis on improving nursing care, expanding health insurance coverage, and improving the quality and equality of care. She has also developed the Foundation's brand, and with it has increased the Foundation's capacity to bring about social change and influence health policy.

Because Lavizzo-Mourey is still serving as president and CEO, it is premature to attempt to assess her legacy. An interview with her, as she looks back on her first decade as the Foundation's president, follows as the next chapter.

Notes

1. This and other quotes from Rogers were taken from his 1994 interview for the Foundation's oral history.
2. This and other quotes from Blendon were taken from his 1991 interview for the Foundation's oral history.
3. Rogers, D.E. Thoughts Regarding The Robert Wood Johnson Foundation's Public Affairs-Public Information Program," Report of the President and Staff to the Board of Trustees, May 24, 1973, p. 116.
4. Blendon, R. J., Aiken, L. H., and Rogers, D. E. "Improving Health and Medical Care in the United States: A Foundation's Early Experience." *The Journal of Ambulatory Care Management*, November 1983, 1–11.
5. Goodwin, P. Personal communication, 2011.
6. This and other quotes from Aiken were taken from her 1993 interview for the Foundation's oral history.
7. See Alper, J. "The Nurse Home Visitation Program." *To Improve Health and Health Care: The Robert Wood Johnson Foundation Anthology*, Vol. V. San Francisco: Jossey-Bass, 2002.
8. See Holloway, M. "The Regionalized Perinatal Care Program." *To Improve Health and Health Care: The Robert Wood Johnson Foundation Anthology*, Vol. IV. San Francisco: Jossey-Bass, 2001.
9. See Lear, J. G., Isaacs, S. L., and Knickman, J. R. *School Health Services and Programs*. San Francisco: Jossey-Bass, 2006.
10. This and other quotes from Cluff were taken from his 1991 interview for the Foundation's oral history.
11. This and other quotes from Cohen were taken from his 1993 interview for the Foundation's oral history.
12. The ten priority areas were: (1) infants, children, and adolescents, (2) chronic illness and disability, (3) AIDS, (4) destructive behavior, including substance abuse and violence, (5) mental illness, (6) organization and financing of health services, (7) quality of care, (8) ethical issues, including unequal access and the rising field of genetics, (9) health manpower, and (10) the impact of medical advances.
13. As quoted in Gardner, J. C. "The Robert Wood Johnson Foundation: 1974–2002." *To Improve Health and Health Care: The Robert Wood Johnson Foundation Anthology*, Vol. X. San Francisco: Jossey-Bass, 2006.
14. The Dementia Care and Respite Services program in 1986, which was replicated in 1992 with the Partners in Caregiving program.
15. Gardner, J. C. "The Robert Wood Johnson Foundation: 1974–2002." *To Improve Health and Health Care: The Robert Wood Johnson Foundation Anthology*, Vol. X. San Francisco: Jossey-Bass, 2006.
16. This and other quotes from Schroeder were taken from his 1995 and 2007 interviews for the Foundation's oral history.
17. SmokeLess States grantees were strictly forbidden from using the Foundation's funds for lobbying.

18. The Center for Public Program Evaluation. "The Tobacco Campaigns of the Robert Wood Johnson Foundation and Its Collaborators, 1991–2010." *RWJF Retrospectives Series*, <http://www.rwjf.org/files/research/72051.tobaccocampaigns.050311.pdf>, 2011.
19. Fighting Back, a program begun under the Cluff administration and expanded in the 1990s. See Wielawski, I. M. "The Fighting Back Program." *To Improve Health and Health Care: The Robert Wood Johnson Foundation Anthology*, Vol. VII. San Francisco: Jossey-Bass, 2004.
20. Free to Grow, on which the Foundation collaborated with the Doris Duke Charitable Foundation. See Wielawski, I. M. "Free to Grow." *To Improve Health and Health Care: The Robert Wood Johnson Foundation Anthology*, Vol. IX. San Francisco: Jossey-Bass, 2006.
21. See Solovitch, S. "Reclaiming Futures." *To Improve Health and Health Care: The Robert Wood Johnson Foundation Anthology*, Vol. XIII. San Francisco: Jossey-Bass, 2010.
22. See Parker, S. G. "Reducing Youth Drinking: The 'A Matter of Degree' and 'Reducing Underage Drinking through Coalitions' Programs." *To Improve Health and Health Care: The Robert Wood Johnson Foundation Anthology*, Vol. VIII. San Francisco: Jossey-Bass, 2005.
23. Ibid.
24. Paths to Recovery—jointly funded with the federal Center for Substance Abuse Treatment—focused, with some success, on reducing waiting times and no-shows and increasing admissions and continuation rates in substance-abuse treatment programs. Resources for Recovery helped states expand their substance-abuse treatment systems. In 2006 the Foundation funded a third program, Advancing Recovery, which sought to implement evidence-based practices in substance-abuse treatment through state-provider partnerships in twelve states.
25. Bornemeier, J. "The Robert Wood Johnson Foundation's Efforts to Combat Drug Addiction." *To Improve Health and Health Care: The Robert Wood Johnson Foundation Anthology*, Vol. XIII. San Francisco: Jossey-Bass, 2010.
26. Palliative care can be distinguished from end-of-life care in that it offers care to all seriously ill patients, whether or not they are dying.
27. Patrizi, P., Thompson, E., and Spector, A. "Improving Care at the End of Life: How the Robert Wood Johnson Foundation and Its Grantees Built the Field." *RWJF Retrospective Series*, www.rwjf.org/pr/product.jsp?id=71944, 2011.
28. The three programs were the Generalist Physician Initiative, under which thirteen medical schools tried to increase the number of generalists by revising curriculum, admissions, and teaching; the Generalist Physician Faculty Scholars Program, which awarded three-year grants to junior faculty members in primary care fields; and the Generalist Provider Research Initiative, which fostered research in primary care.

36 TO IMPROVE HEALTH AND HEALTH CARE, VOLUME XV

29. See Wielawski, I. M. "Practice Sights: State Primary Care Development Strategies." *To Improve Health and Health Care: The Robert Wood Johnson Foundation Anthology*, Vol. VI. San Francisco: Jossey-Bass, 2003.
30. See Wielawski, I. M. "Reach Out: Physicians' Initiative to Expand Care to Underserved Americans." *To Improve Health and Health Care 1997: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 1997.
31. The Partnerships for Training program. See Green, L. "Improving Health Care in Rural America." *To Improve Health and Health Care: The Robert Wood Johnson Foundation Anthology*, Vol. XII. San Francisco: Jossey-Bass, 2009.
32. See Diehl, D. "The Southern Access Rural Program." *To Improve Health and Health Care: The Robert Wood Johnson Foundation Anthology*, Vol. X. San Francisco: Jossey-Bass, 2007.
33. This quote from Wentz was taken from his 1995 interview for the Foundation's oral history.
34. See Morone, J. A. "The Robert Wood Johnson Foundation and the Politics of Health Care Reform: Communications, Advocacy, and Policy Development." *To Improve Health and Health Care: The Robert Wood Johnson Foundation Anthology*, Vol. XII. San Francisco: Jossey-Bass, 2009.
35. See Rosenblatt, R. "The Robert Wood Johnson Foundation's Efforts to Cover the Uninsured." *To Improve Health and Health Care: The Robert Wood Johnson Foundation Anthology*, Vol. IX. San Francisco: Jossey-Bass, 2006. See also Nakashian, M. "Increasing Health Insurance Coverage at the Local Level: The Communities in Charge Program." *To Improve Health and Health Care: The Robert Wood Johnson Foundation Anthology*, Vol. X. San Francisco: Jossey-Bass, 2007.
36. The Cash and Counseling program. Benjamin, A. E., and Snyder, R. E. "Consumer Choice in Long-Term Care." *To Improve Health and Health Care: The Robert Wood Johnson Foundation Anthology*, Vol. V. San Francisco: Jossey-Bass, 2002.
37. See Newbergh, C. "Improving Quality of Care." *To Improve Health and Health Care: The Robert Wood Johnson Foundation Anthology*, Vol. XII. San Francisco: Jossey-Bass, 2009.
38. McGlynn, E. A., and colleagues. "The Quality of Health Care Delivered in the United States." *Journal of the American Medical Association*, 2003, 348, 2635–2645.
39. See, for example, Levy, A. D. "The Robert Wood Johnson Foundation's Efforts to Address Pediatric Asthma." *To Improve Health and Health Care: The Robert Wood Johnson Foundation Anthology*, Vol. XII. San Francisco: Jossey-Bass, 2009.
40. McGinnis, J. M., and Foege, W. H. "Actual Causes of Death in the United States." *Journal of the American Medical Association*, 1993, 270, 2207–2012.