

Conversations with Steven A. Schroeder

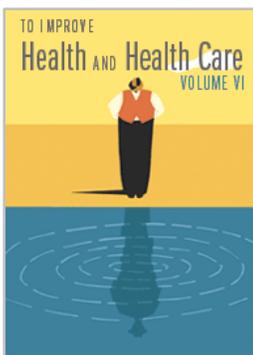
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Robert Wood Johnson Foundation

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and Health Care,
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Editor's Introduction

Steven A. Schroeder retires as president and chief executive officer of the Robert Wood Johnson Foundation at the end of 2002. He will be succeeded by Risa Lavizzo-Mourey. An internist by training, Schroeder came to the Foundation in 1990 from the University of California at San Francisco, where he had been professor of medicine, medical director of a university-sponsored health maintenance organization, and founder of the Division of General Internal Medicine.

During his tenure, the Foundation's assets grew from \$2.8 billion to approximately \$8 billion, and the Foundation developed new programs to reduce substance abuse (particularly tobacco), improve care at the end of life, support coalitions of volunteers assisting homebound people, expand health insurance coverage for children and promote physical activity. Under his guidance, in 1999 the Foundation was reorganized into two groups, one focusing on health care and the other on health. In response to the Foundation's growth, he also oversaw the renovation and expansion of its headquarters.

In this opening chapter, Renie Schapiro, a writer and consultant to the Robert Wood Johnson Foundation, conducts a wide-ranging interview with Schroeder. The chapter offers a rare opportunity for the chief executive of the Foundation, the nation's fifth largest, to reflect candidly on the issues faced by the Foundation over the past twelve years, and on the state of health and health care in America.

RS: Let's begin long before you came to the Robert Wood Johnson Foundation. What drew you to medicine and to the career choices you made along the way?

SAS: What drew me to medicine was a desire to do good, which came out of a family background steeped in humanism and social justice. I thought about law initially, but it is so tied to precedent and I was interested in mountain climbing and science fiction and wanted to try to deal with new, open areas. That led me to psychiatry, which seemed like a frontier in health. I was interested in people and behavior, and I thought that by being a psychiatrist I could tap into those interests. The other component of my career choices was that I wasn't a very disciplined student as a young boy, and I didn't shine in the sciences. So I thought I could dodge that hurdle by going into psychiatry.

RS: You ended up in internal medicine. What happened to psychiatry?

SAS: I had a very bad experience in my first class in medical school: I flunked my biochemistry midterm. It made me realize that I had to study harder. Once I started studying and coming back to the sciences, I realized that I liked them more than I had thought. So I saw other aspects of medicine as being possible. Then I took my psychiatry rotations during my third and fourth years of medical school, and the field just didn't fit with what I wanted to do. My interest morphed into how to combine medicine and public health.

ON COMING TO THE ROBERT WOOD JOHNSON FOUNDATION

RS: You certainly did that. You have had experience in academic medicine, public health, and health policy, and as a Robert Wood Johnson Foundation grantee. How did that unusual combination of experiences affect your approach to the Foundation's presidency?

SAS: I was sort of a risky choice for the Foundation, because I hadn't had a lot of senior-level experience as a manager. I was medical director of two university-sponsored health maintenance organizations, and I had run a rather large academic division of general internal medicine, but a division within a department within a school is relatively low in the academic hierarchy. I had tried to understand clinical medicine; public health; and health care organization, finance, and policy, so I probably had more breadth than the average person in medicine. That kept me from being locked into any particular approach and left me with a sense that the Foundation should do whatever it takes to make things better in the broad scope of health and health care.

RS: In a sense, you represented a new generation of presidents. You are only the third person to hold the job. Your immediate predecessor, Lee Cluff, was from the inside and held it on an interim basis. Did you feel you were creating a template for the presidency of this organization?

SAS: To be frank, when I first got here, I worried that I was going to get fired. There was some tumult within the Foundation. I had heard that there was friction between board and staff, and I thought the agenda I was bringing was much more of a social activist one than the Foundation had seen previously. So I wasn't thinking nearly that grandly.

RS: When you first came, what did you hope to accomplish?

SAS: I said, "I want the best possible programs. I want this to be the best possible place to work." That's still true. I also wanted us to make a difference. I thought the Foundation probably hadn't linked up its moral capital sufficiently to a vision of where the country ought to be with health and health care. I wanted to revise our goal statements to have them be less about grantmaking areas and more about where the country should be.

We did that by establishing three goals. The first goal was to ensure access to basic health care for all Americans. The second was to improve the way people with chronic illness are treated in our health care system. The third was to reduce the harm caused by substance abuse. These were framed as social goals, and they furthered the Foundation's wonderful mission statement of "improving the health and health care of all Americans."

RS: Explain what you mean by *moral capital*.

SAS: I mean using the Foundation's reputation as an organization that is trying to make a positive difference. So if we say something is important, it may mean something. We've been told that the imprimatur of our name given to local organizations or people can be helpful. We do that, for example, in the Community Health Leadership Program and the Local Initiative Funding Partners Program, two programs that recognize local leaders. When we convene a group to tackle a problem, like the one we brought together to speak out on the need for broader health insurance coverage, that is drawing on our moral capital.

Another example of using moral capital—another way I’ve tried to say something is important—is by writing and speaking. By taking on subjects like the uninsured and substance abuse. I have not been as much of a public figure as others might have been, and that’s partly personality. I don’t particularly enjoy being in the public eye. And there’s a fear that we are so big we might be viewed as being sort of a bully. So I’ve tried to use our influence but not overdo it.

ON GRANTMAKING STRATEGIES

RS: Let’s talk a bit about grantmaking strategies. Given that your health services research was focused on effective use of health care resources and reining in profligate spending, it must be especially hard not to wonder if you are making the best use of the Foundation’s money.

SAS: I think that’s the major challenge in philanthropy at the end of the day: the nagging worry that you didn’t do enough. It’s a valid concern. I couldn’t sit here and tell you that we’ve made the best possible use of the billions of dollars that we’ve spent.

RS: If you could start again, what would you do differently?

SAS: There’s a tension in a philanthropy in trying to achieve your goals while also trying to work with your historical constituencies and to engage the interests of the staff, who come in with their own interests and needs. What I could have done is really start fresh in a certain direction. Other than believing we should grow the health portion—that is, the portion having to do with nonmedical factors such as smoking and drug abuse that affect people’s health—I wasn’t at all sure when I got here that I understood how philanthropy worked well enough to say, “Let’s make a radical change.” So our change has been incremental.

I probably could have been a tougher manager and said no more often to some of the grants. There were some grants the staff worked very hard on that weren’t bad, but even though they weren’t really terrific in my view I still signed off on them. I worried that the consequence of saying no more often is that you turn off the staff, and you need to give them the freedom to develop things. But in retrospect, perhaps I could be faulted for not being tough enough.

RS: Foundations can and do take various approaches in dividing up their money. Some endow institutions or make very large grants, some focus on a goal that’s probably achievable and can be easily

measured, others spread out hoping to hit a home run somewhere. Where does the Robert Wood Johnson Foundation fit on that continuum?

SAS: I've had the luxury of working here in a rising market, so we've had the privilege of having a pretty diverse set of strategies. The common wisdom in philanthropy is that the more focused, the better. The counterpressure is that interesting problems come up—bioterrorism, you name it—and so there's always a tendency to want to go after new things. I think my leadership style has been to try to keep a balance, both in the mixture of large and small grants and in the desire to focus and yet not be too rigid about it.

RS: You mentioned the endowment's growing so much. Does that change your strategy? Do you make larger grants because you have more money, or do you basically do more of the same?

SAS: That growth permitted us to fund some very large programs and to increase our priority on improving health, essentially from zero, without being seen as taking money away from our health care work, such as expanding health insurance coverage and improving care for people with chronic illnesses.

RS: What happens when you have expanded programs in place and the market drops?

SAS: We have a multiyear program planning and budgeting process, so we're well positioned to respond to market changes. I do believe that discipline is important. When times get harder, you have to see what your real priorities are and what would be nice to do this year but you can't—that's a very helpful exercise.

RS: What have you learned about philanthropies working together?

SAS: It isn't done nearly as often as it should be. That's related to the fact that the transaction costs are often great because each foundation has its own board and staff, culture, rules, and procedures. Our Local Initiative Funding Partners Program, which is larger now than when I got here, is probably a model for large foundations working with smaller ones. I don't think any other national philanthropy does that. We've been less successful in working with other large foundations—there are only a handful of examples where we've done it. I'm not proud of that.

RS: It's almost a cliché now that foundations can take risks and even fail sometimes. Yet foundations in general have a reputation for being pretty staid and not often out front. Why is that?

SAS: I think that the reluctance to take risks is mostly staff-driven, although trustees often get blamed for it. You get staff members coming to work for a foundation who are drawn by the mission; they want to do social good. They have to work with others, so it's very hard to measure how much good they've done and how much impact they've had as individuals. One way they can do it is to see how many of the programs they work on get funded. The riskier your program is, the harder the sell to your colleagues and the board; that's a disincentive to take risks. The other thing is that sometimes a risky program blows up. Then, of course, there's the question "Why did you support that, and what could you have seen coming?"

Boards can figure into this risk aversion, too. Some foundations' boards are drawn from people who, for a variety of reasons, don't want to take risks. There are many kinds of risk: of failure, of not making a difference, of controversy, of politics. When people talk about foundations being able to take risks, they're not very precise about what they mean. But with regard to really going out on a limb for a particular program, there's no question that the staff and the board—and the leaders—can be resistant.

RS: So it sounds as if "I'm willing to fail" and "Sometimes a program will blow up" haven't really been incorporated into the culture.

SAS: We talk about that. Once in a great while, we bring a program to the trustees that they don't like, and they turn it down. That actually happened to me once. I wanted to help the Chinese government develop a proposal to hold the World Conference on Tobacco OR Health in Beijing, and the board said no. At the staff debriefing later that day, I said to them, "Now I know how you feel."

There is this sense that being turned down is a terrible thing. It really shouldn't be. But it's very human for the staff to feel "I don't want to take that risk." Some are more comfortable doing it than others.

RS: Accountability has been a major concern of yours. What's the challenge there?

SAS: When I was in academic medicine, at the end of the year I could give myself and our academic unit letter grades. How well have we done in getting research grants? getting papers in the respected journals? Did the faculty get promoted on schedule? How did we do in recruiting faculty? in the residency

program? What was the fiscal bottom line on our patient care? What do patients think of us? How do we do as teachers? How did we do in getting grants? I could have a pretty accurate measure.

At the Foundation, we're trying to improve access to care, create better end-of-life care, reduce smoking, and the like. The results are hard to measure. Many factors contribute to the problems we are addressing. If things get better, do we take credit? If they get worse, do we say, "It would have been even worse if we hadn't acted?" So we do polls and do measurements and try to be as specific as possible on our grant strategies, but it is still hard to know how much impact we've had. Ultimately we're forced into word-of-mouth and a gut sense of how much we've been able to influence a particular field.

RS: Have you arrived at anything approaching a formula for which problems are susceptible to change and which are recalcitrant?

SAS: When we're deciding whether to fund a national program or enter a new area, we go through five steps (not necessarily in sequence). First, how important is the problem? Second, how could it be made better? Third, who is working on it? Fourth, what has been the experience of those working on it? And fifth, how does it fit with what we could do with our culture, with the talent that we have here, and with the amount of money that we have?

One realization I've come to is that we tend to overemphasize strategy and underemphasize execution. A key component of execution is leadership. The people we've picked to lead our big programs probably had more to do with their success or failure than the very elegant strategy that we may dream up here. I think that we sometimes get ourselves into a box by either overpromising when we develop a program—that is, we oversell it—or, conversely, by being so vague that at the end of the day we can't really tell whether it did what we thought it was going to do.

But how to take a bite out of a problem is still pretty much an art form. One thing that we've done, particularly in health, is to try to give more importance, more support, to an underdeveloped field. We've done that with substance abuse and care at the end of life; we're going to do it more with physical activity, and to some extent with public health. The Foundation can support people who are doing good work in an area and have good ideas about how to make things better. That's been easier in health than in health care, because it's a less crowded field.

RS: Have you changed your notions of grantmaking strategy over your twelve years?

SAS: I've come to rely less on academics as a stimulus for social change. It's much more obvious to me now that grassroots movements and the media and politics are very, very critical. At least in the era since I've been here, academic medicine has been much more reactive than proactive. So I guess I've looked elsewhere for solutions to some of our more difficult social problems.

RS: Do you come away from your experience here struck more by how much the Robert Wood Johnson Foundation can accomplish or by its limits?

SAS: Both. I think the integrity and the reputation of our Foundation are great. On the other hand, it is sobering to see that social change comes very hard. That doesn't mean it's not worth trying, but it is daunting.

RS: Does the Foundation do enough to build on its successes?

SAS: On the continuum of foundations that stay in too long and foundations that get out too quickly, we probably tend to stay more with things. Do we do all we can to harvest what works? No, of course not. But I don't think one could accuse us of being a hit-and-run philanthropy.

ON PRIORITY AREAS

RS: Looking back at the Foundation's priority areas—access to care, substance abuse, chronic care, and the more recent focus on physical activity under health—how do you feel about those choices now?

SAS: I feel good about our goals. It's at the next level down that I think we need more work, and I hope that as the next president, Risa will be able to help us develop even better strategies and execution.

RS: I'd like to take you through the three priority areas—substance abuse, chronic care, and access to health care—that were established shortly after you arrived at the Foundation, and ask you to reflect on what you think the Foundation accomplished, what lessons were learned, where that field is now, and where it's headed. Let's start with substance abuse and what you think the Foundation's investments have yielded.

SAS: I think we helped to mainstream the field. Since we are one of several voices, it's hard to know how influential ours is. But I think that as a result of our efforts, more attention is being paid to the importance of substance abuse as a social issue that affects many parts of our life. Institutions we've supported, such as the National Center for Alcohol and Substance Abuse at Columbia University, the National Center for Tobacco-Free Kids, and Join Together, are speaking out on these issues.

There's more flexibility about alternatives to incarceration—for example, with young people who use drugs. I think we've effectively served as a counterforce to the tobacco industry. There's more support for efforts to reduce the harm from drinking and drug use. Because we've taken some of the stigma out of working in the substance abuse field and lent it some of our prestige, we've made it safer and more inviting for academic and social leaders to enter.

RS: What lessons do you take away about how to make progress in reducing the damage caused by substance abuse?

SAS: Strong, effective leadership at all levels is a critical, important lesson. Especially in the antitobacco world, we found that there were warring camps— it was a little bit like Beirut—with many well-intentioned people working very hard who didn't necessarily want to pull oars together at the same time and with the same strength. That hurts the effort. We were able to have some effect on this through our convening role, but not as much as would have been desirable. Particularly at the outset, there was a fair bit of jockeying for position, and dogmatism. You know: "My way is the right way." Probably that's a characteristic of this field.

A second lesson is that in a field as complicated as substance abuse, you're probably smart to go with multiple strategies, and we did that. We sponsored research, funded surveys, supported a Bill Moyers television special, and helped to start institutions and form state and local coalitions. What would have happened if we'd put the same resources into just one strategy? Since we didn't do so, it's hard to know. But I have a feeling that in social movements like this, it's useful to invest in a variety of strategies.

Another lesson is the difficulty of mobilizing grassroots organizations to speak on behalf of people who have been harmed by substance abuse. With important exceptions such as Mothers Against Drunk Driving and Students Against Drunk Driving, there's no group of people lobbying for them. One disappointment is that we haven't been able to kick off a movement of concerned people—relatives of

people who died of smoking or whose lives have been destroyed by alcohol or drug abuse. We have tried, though maybe not robustly enough. It's hard for foundations to start a social movement.

RS: Finally, your assessment of where the field stands now, and where it's headed.

SAS: It's becoming more mainstream. There is an increasing realization that the dollars spent in treatment are not wasted, although I must say that there's still a deep skepticism about whether treatment's worth it. People don't see that substance abuse treatment is like lots of other chronic disease treatment. People don't grumble if diabetes or cancer aren't cured; they still think treatment is worthwhile. But they require a much higher standard of efficacy with substance abuse treatment. Still, the realization is growing, and there is less dependence on supply interdiction. There's also more appreciation that countermarketing, both with illicit drugs and tobacco, can be a very effective prevention strategy.

In alcohol, there have been some new ideas, such as the concept of secondhand drinking that Henry Wechsler of Harvard University has put forth with our support. The idea is that just as secondhand smoke does, drinking causes collateral damage to nondrinkers—for example, on college campuses, whether it's date rape, noise that disturbs studying, drunken driving, or vomiting on a roommate at the end of a binge night. There is the realization that binge drinking on college campuses is quite prevalent, which people haven't thought about much.

Where the field is headed is also tied to exciting new scientific work. Back in 1991, we said we're going to work on all types of substance abuse, without really understanding quite how much common central nervous system dopamine pathways and serotonin pathways are involved in addiction—that there may be solutions or treatments common to various types of addiction. The neurotransmitter and brain chemistry changes that scientists are now documenting will influence the direction of the field. I think there is going to be exploration of methadone-like substitutes for cocaine, and for pharmacological treatment of both drinking and cocaine use that parallels the work with heroin and methadone.

RS: Let's move on to chronic illness and what the Robert Wood Johnson Foundation has accomplished in that area.

SAS: The highlight of our chronic illness work probably has been care at the end of life. It's almost a signature program for us. We funded a major study that showed, unfortunately, that terminally ill

patients—even those who had signed a living will or health care proxy—were suffering needlessly. After that, we helped launch a movement to improve the situation. We've worked with others, such as the Soros Foundation, to raise public expectations about what care at the end of life should be—for example, that people shouldn't have to suffer great pain and that health care professionals, clergy, and families should be more sensitive to this. My guess is that the country will do better on care at the end of life, and that we can take some credit for it and feel good about our role.

In terms of quality of care—narrowing the gap between what we know works in chronic illness and what actually happens—I don't think we have had much of an impact yet. I'm very hopeful that our new work on improving the quality of care will make a difference.

In the supportive services area, our Partners in Caregiving program (which supports adult day centers) and our Faith in Action® program (which funds local religious groups to help chronically ill individuals) have the potential to bolster a community support system and allow people to stay in their home longer, rather than go into a nursing home. That's what most people want, so I think we've made a contribution there, too.

But we've probably accomplished less in chronic care than in the two other priority areas, substance abuse and access to health care services. In terms of quality, compassion, and efficiency, as good as our system is, it could be much better. The problem is, it's tough making it better because there is so much noise in the system—so many people and players and so much money. The Foundation has much less leverage.

RS: How do you get consumers to demand better chronic care?

SAS: It's easier to get outraged about, say, smoking, because there's an industry that's pushing a product that's harmful and whose tactics over the years have been very deceptive. It's harder to feel outrage about your doctors or your nurses or your hospital, because much of what they do is wonderful.

So you tend to see family members or survivors advocating around a specific disease, and what they generally want is a bigger piece of the pie. The collective message from those voices is just "More for everyone," and the louder the voice, the better the chance you have. One of the problems is that people

with chronic illness are not liable to be heard as much in the political process. Ultimately, I think the system is not going to get better until the customers and the people working in the field want it to.

RS: Let's move on to access to care. The issue of medical coverage has been a passion of yours. You've spoken about the immorality of having so many uninsured in this country. Yet the problem isn't going away.

SAS: It sure isn't.

RS: Are you discouraged?

SAS: I'm generally a glass-half-full person, but I must say that it's disappointing to see the lack of interest, both at the political level and in the health professions. In general, the leadership from medicine and nursing hasn't been there on this issue. On the positive side, support may be coming from some unexpected places—such as AARP [American Association of Retired Persons]. Even though most of the members have Medicare coverage, AARP's president, Bill Novelli, has said that coverage is an important issue for the organization because inadequate coverage earlier in life makes for less healthy older people.

RS: What's it going to take to change the situation?

SAS: I'm not sure I know. Cost containment and the focus on medical expenditures have been so distracting and consuming that the health professions have not been able to work in a concerted way for more noble causes. On the other hand, they didn't work much for them earlier, either. So maybe it's too much to expect that professions or industries will do something other than argue in their own self-interest—although I would say it is in their self-interest to have everybody covered.

I think one of the unattractive aspects of our country is the relative lack of concern about the less fortunate. From time to time, I've wondered whether we should get out of the business of trying to expand health care coverage. Then I ask myself, "What kind of a signal would it send if the nation's largest philanthropy in health and health care gave up on trying to make sure that people have health insurance?" So we've stayed in. I think we've done some very good work, but frankly, we haven't had either the creativity or the muscle to bring about change. Nonetheless, it remains a strong commitment for the Foundation.

RS: That brings up the tough period in the Foundation's history when it was linked with the Clinton plan. How do you look at that now?

SAS: Well, I learned that I was very naive about how the political process worked. From my standpoint, I thought, "Here's our new president; he and his wife are going to try to make a health plan. She doesn't have a lot of experience in health care. They asked us to help them to better understand the field." And our board, which had mainly Republicans, said the Foundation should help. We agreed to fund four regional meetings on health reform—"listening sessions." But in the execution of these meetings, I don't think we were nearly sensitive enough to the political nuances. So we were criticized, probably appropriately.

RS: What do you mean by not "sensitive enough to the political nuances"?

SAS: What happened is that the meetings became media events, with Mrs. Clinton being the focus, which elevated her profile and, by inference, her party. I sent transcripts of the four meetings to some people who had been critical of us for what they said was support of the Clinton health plan. Of course, those meetings took place as the task force was getting started, so there wasn't a Clinton health plan yet. When our critics read the transcripts, they stopped talking about that, because the transcripts themselves are quite innocent. But I don't think we were nearly sensitive enough to how it was going to play. We should be criticized for our naiveté.

What sobered me in the four listening sessions was the sense that everybody wanted more of everything and nobody was willing to say what there should be less of. At the end of those sessions, I went away pretty much convinced that we weren't going to get a national health plan—that the Clinton administration wasn't going to be as successful in achieving that as many people thought then.

RS: What about roads not taken during your tenure?

SAS: Two health care areas that we could have taken on more frontally are cost and quality. Costs were sort of an early semi-goal. We've helped support some of the intellectual work on costs—such as research done by Jack Wennberg and his group at Dartmouth that showed how much medical costs varied regionally—but it's very hard, in my view, for us to be a player in keeping costs down. So many forces are

beyond our reach; we don't influence how payments get set, or supply or demand. Yet, without some control of costs, we're never going to get on top of access.

We were also concerned early on with improving quality of care. The field was quite fragmented, with a limited number of dominant leaders having different views of the right strategy to make quality better. So we went at it indirectly, choosing to focus on improving the quality of chronic care. It looks as if we are moving quality and chronic care together; my guess is that the natural trend is to link them more closely.

ON STAFFING AND MANAGING THE FOUNDATION

RS: You've said that one of your greatest sources of satisfaction at the University of California, San Francisco, was attracting good staff. Let's talk about your staffing philosophy here. Your predecessor, David Rogers, hired smart generalists and worked them hard for a few years, and then they moved on. Some of those people—Drew Altman, Bruce Vladeck, and Linda Aiken, to name a few—went on to assume leadership positions of other major organizations and agencies. You seem to hire more senior people and more specialists. Do you see this as more of a place for people to build and complete their career?

SAS: I realized quite early that the success of the programs was going to be a direct result of the quality of people working on them, and I wanted to get the best possible staff people and keep them growing and energized for as long as I felt the Foundation was getting value from them. I inherited a strong staff, but I think it's even stronger now. We've been very successful in recruiting high-quality people. I was fortunate to be here when our assets were growing so we could continue to bring in talented people.

We are more differentiated now than we were in the seventies, and we need some generalists and some specialists. What characterizes the staff members is that they're mission-driven and work very hard. They can and should disagree on strategies—we probably don't have as much disagreement as we should, though there's a fair bit of it—but no one questions motives, and there's a lot of respect for one another. It's not that we don't have our issues, but I think this is a good place to work and people recognize that.

What's been interesting is that we'll bring in someone with a background in *X*, but they'll get fascinated with *Y*. We give them that opportunity to work on *Y*. Very few people work in only one area. The danger of hiring specialists, of course, is that if we shift out of their area of expertise, their background doesn't

necessarily fit. But we don't usually bring a specialist in unless it looks as though his or her field is going to be an enduring part of our programming. We bring in people at all points in their careers.

Because we are so much larger, there's been a devolution of management of the program to outside the office of the president. I feel that's appropriate.

RS: Does that devolution—now organizationally into two units, each with five teams—jeopardize the focus that you have said is so important?

SAS: Well, people speak differently on that. Some inside critics feel that ten teams are too many. As I look at the aim and the content of each team, the teams make a lot of sense to me. If you push me, I would say we could probably merge maybe one or two of the teams into others.

RS: Staff and grantees must wonder how your leaving might affect their work. Can you describe what changes might come with a new president? What is there about the institution that will endure?

SAS: A foundation is probably more sensitive to a change of leadership than most institutions, because of the difficulty in measuring a bottom line, and the fact that the power flows very directly from the board to the president to the staff. In that sense, a president has the potential to make a major difference in the direction of a foundation, and I've seen that with some foundations.

Having said that, I believe there's a lot of continuity in the Robert Wood Johnson Foundation. For example, our programs to increase access to care and to improve the health care workforce—as through our Clinical Scholars Program®, Health Policy Fellowships, and our programs to increase the diversity of the health care workforce—stretch back to the Foundation's beginning in 1972. The board has indicated it's pleased with the direction that the Foundation is going; they would like us to do better and be able to measure better how we are doing, but they have not indicated that they want any major changes. So my guess is that Risa, as the next president, will make some changes, but they'll be evolutionary rather than radical. But we'll see after she has a chance to survey the landscape.

Our mission—improving health and health care—is much more focused than that of other big foundations, and we are likely to stay in both. But I don't think that our priorities ought to be fixed in

stone. Things change, opportunities change, problems change, so I would guess that Risa will take a hard look at what we're doing and work with the staff to explore possible new directions.

RS: The core commitments and values you developed lend some continuity, too, don't they?

SAS: Yes. Let me talk about those for a moment. One of the options I once floated to our board as a way to respond to the Foundation's growth was having a "subfoundation" off-site. A board member, David Clare, who had been the president of Johnson & Johnson, stressed to me the importance of the company's credo as a North Star for Johnson & Johnson employees. If you have people off-site, he said, you need a set of enduring values that they can come back to, and that got me thinking and talking, and ultimately it resulted in the core commitments and values.¹

ON LEGACY

RS: Your imprint, your legacy: What do you see as the three or four most important changes you've shepherded?

SAS: From the inside, helping to get a national board of trustees. When I got here, I was the youngest of eighteen white males, all from the East Coast. We were ripe to move to a more national board. Second, improving the communication between our board and staff, in part by having the staff attend board meetings, and featuring them. I'm very proud of our staff, and I wanted to expose them as much as possible to the board, and give the board a good sense of how things work here. The third legacy is the high quality of the people we have here. And we've got a wonderful new building that houses the Foundation.

More important, though, is, What difference have we made with the billions of dollars that have been spent since I came here? I would identify probably four or five things.

Growing the health part of our mission was especially important. We established programs first in substance abuse, then to encourage physical activity, and more recently to bring about broader behavioral change. We've also helped to build the field of population health.

In health care, I think our staying the course—the Don Quixote, the Sisyphean course—of trying to get people covered with health insurance has been the right thing to do even though it's a tough battle.

Taking the negative results of the SUPPORT study on improving end-of-life care and helping to mold

that into the end-of-life movement is a legacy of the Foundation. Some of our work in quality of care that we're starting now may turn out to be a legacy. Faith in Action, our program to help religious organizations whose members provide supportive services to their chronically ill neighbors, clearly has the possibility of becoming a legacy too. We not only stayed the course with the minority health professional programs (which have come under so much fire in some quarters), we've expanded them.

But I don't think of these accomplishments as my personal legacy; I think of them as a legacy of my era here, which is different.

RS: Is there a particular accomplishment, a particular grant, a particular change that has given you the greatest personal satisfaction?

SAS: The Foundation's work on smoking is near and dear to my heart, because tobacco is such a huge health hazard and philanthropy was conspicuously silent about it. I've felt that it was something we should be doing, and we now have a strong presence in the field.

RS: What was most disheartening or disappointing?

SAS: That we have more people uninsured now than we did when I got here. It's a double-barreled disappointment. It demonstrates to me daily the limits of what we can do as a foundation. It also illustrates the less desirable qualities of our country.

RS: You did a listening tour when you first assumed the presidency. If Risa does that, what is she going to hear?

SAS: I'm not sure. One of the dangers of a job like mine is that you don't always get the truth. People often tell you what they think you would like to hear, or they sort of lobby you. It's very hard to find a disinterested voice.

But I guess they would say that we could be more focused. Probably that we're more inbred than we should be, that we need to explore other grantees; we do tend to have a group of people whom we go back to often, because we think they're good, but also because we're comfortable with them.

They probably would say that our staff needs to continue to get out into the field as much as possible. I like to think that we are more customer-friendly with our grantees than we were, but I'm sure they would say that we could do better.

Then I suspect too that you'll get a variety of people pointing to what they think are our strongest programs and our opportunities for growth. To a large extent, that's a function of whom you talk with. When Lee Cluff took over as president, he sent a letter to a number of leaders in the field, saying, "I know you're a leader"—in mental illness or child health, let's say—"but knowing the Foundation's mission and what we've done in the past, all that we might do in the future, where do you think we should concentrate our efforts?" I looked at those documents when I got here, and found that people would rarely go beyond their own area. For example, the person with a background in mental illness would say, "Well, I think you should focus more on mental illness." As a result, when we looked at new areas when I got here, we did that as a staff function. We didn't use an outside task force.

RS: Do you come away from your time here with a different sense of what strategies work than the one you had in academia?

SAS: Convening, influencing public opinion, and social marketing are three very powerful tools that I didn't use much as an academic. I'm more impressed with what grassroots activism can do. For example, bone marrow transplantation for metastatic breast cancer was basically forced on commercial health insurers by grassroots advocacy groups at a time when there was no scientific evidence it was a useful treatment, and subsequent research indicated it isn't useful. That's a very powerful message.

My model of social change starts with the ballot and with campaign financing, which our Foundation can't do much about. If only 50 percent of the people in this country vote, and those who don't vote tend to be concentrated in poor and minority communities, then we shouldn't be surprised that they don't get as much from the system. So if I were reincarnated as a social change maven, I might work to try to get communities more active in expressing themselves politically.

RS: That's my next question. If you were starting your career again, what big lever for social change would you target?

SAS: I think we kid ourselves when we think that there is any one big lever. Social change is very hard work. The media—especially TV—has so much power, for better or worse. I would probably say—and I

wouldn't have said this twelve years ago—that one of the most important people in our country right now is Oprah Winfrey. If you can get her to champion a social cause, then you have a very visible and influential advocate.

RS: How did you take that insight into the communications work the Foundation has done during your tenure?

SAS: We have expanded our communications activities significantly. We've supported some television and radio work, tried to create messages, looked to social marketing techniques, and supported advertisements about health insurance coverage, to give a few examples. We're more conscious of communications as a strategy.

ON THE FUTURE

RS: What do you see as the major health issues in the coming years?

SAS: In health care, I see we're really in a box now. The clinical enterprise is growing by leaps and bounds, with the real promise of helping people lead longer, healthier, and more functional lives. But this comes at a great price. People don't want to be denied any access to medical care, but no one wants to pay for it. Politicians and the press are loathe to raise these kinds of issues. We've got about forty million people who don't have health insurance, and many others who are underinsured. So I see that as a collision course.

In the health area, we're becoming more aware that many of the determinants of health lie outside the health care system. They depend on personal behavior. Yet we have a nation that's becoming more overweight and less physically active, and there's growing evidence that physical activity may be as important in preventing illness and improving functioning as not smoking. Trying to change personal behavior, however, is very, very hard.

We're also beginning to understand that being connected to one another may have an important role in health. All things being equal, people who are more extroverted and have more friends are likely to be healthier than people who are isolated in their community.

Another really tantalizing bit of information is that it looks as though relative income inequality may be a risk factor. It isn't how poor you are, but how *relatively* poor you are. People in the second quintile of

wealth are less healthy than people in the first quintile, even though that second quintile is very comfortable. Researchers don't fully understand why, but they think it probably has to do with stress and the degree to which people feel in control of their lives.

So I see us sort of plunging down the health care technology track to try to make our lives healthier, while the real secret may lie elsewhere. On the other hand, when we get sick, we all want as much medical care as possible.

RS: What piece of advice are you going to whisper to your successor?

SAS: I would say things like I said in my "President's Message" in this year's *Annual Report*: mission matters; execution trumps strategy; you've got to know when to hold 'em and when to fold 'em; and don't underestimate the importance of leadership. I would say this is a very visible position, and people watch what you do. I discovered the symbolic power of what you do and say. So be a very self-aware leader.

Be as optimistic as possible. Try to listen really hard. A wise trustee told me quite early that you're not going to get criticized much, so if you hear some criticism, it's probably the tip of an iceberg and you should take it very, very seriously.

Challenge what's being done. Ask, "Why are we doing it?" "Could we do it better?"

RS: What are you going to be doing next?

SAS: I'm going back to the University of California, San Francisco faculty, as Distinguished Professor of Health and Health Care. I'm going to be working on a program with the Foundation related to tobacco and the health professions.

I'm on a number of interesting not-for-profit boards and hope to use them, and the experience and knowledge I've gained, to continue to be a voice for things that I care about.

RS: What if I told you that the board has just decided to move the Robert Wood Johnson Foundation to San Francisco and extend your contract? What would you do?

SAS: I would sigh! And I'd say, "Wow, that's very tempting." But I'm not leaving just because I want to go back to San Francisco. I really do feel that the renewal of an institution is very important. I worry that I might have gotten stale, or may be getting stale, or may become stale soon. I think there is a wonderful virtue to a foundation—to any kind of an organization— taking stock of itself periodically. The exit of a leader is a wonderful opportunity for that kind of self-assessment. But as much as I say that it's good to leave this kind of job, it's going to be painful, too.

Notes

Schroeder set forth the Foundation's core values in his Foreword in *To Improve Health and Health Care 1998–1999: The Robert Wood Johnson Foundation Anthology* (Jossey-Bass, 1998).