

# Health, Health Care and the Robert Wood Johnson Foundation: A Ten-Year Retrospective, 1996–2006

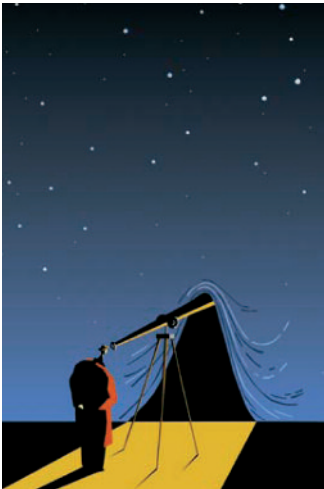


Robert Wood Johnson  
Foundation

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## *Editors' Introduction*

To mark the tenth anniversary issue of *The Robert Wood Johnson Foundation Anthology* series, the editors wanted to take a retrospective look at how health and health care have changed in the decade between 1996 and 2006 and how the Robert Wood Johnson Foundation's approach to the issues has evolved during the same time period. We decided to undertake the task ourselves, in collaboration with David Morse, the Foundation's vice president for communications. Morse has been an active participant in the development, editing, production, and distribution of the *Anthology* series. In addition to investigating how health, health care, and the nation's fourth largest foundation have changed during the decade, we were also curious to find out whether external events had influenced the Foundation's policy agenda, and if so, how.

Taking 1996 and 2006 as fixed comparison points is somewhat arbitrary. What happened in those years cannot be wholly separated from events that occurred in the preceding years—or, for that matter, the following years. Health care in 1996, for example, cannot be divorced from the attempts at reform that ended a few years earlier. Similarly, the Robert Wood Johnson Foundation's strategies in 2006 reflect decisions made in 2003 when the Foundation adopted an "impact framework" to guide its grantmaking. As we have learned, the Foundation's grantmaking strategies depend to a great extent on the perspectives of the Foundation's president, but they are formulated within the framework developed over many years by the Foundation's staff and trustees.

In a sense, in this chapter we try to answer the question, "How did the nation's largest health foundation approach its mission—to improve the health and health care of all Americans—at two different times set a decade apart?" To find the answers, we first look at how the public and health policy experts saw health and health care issues in 1996, and then again in 2006. We then explore the Foundation's strategic priorities in 1996 and 2006, how they evolved, and why. We then look at the interrelationship between societal concerns and the Foundation's programming to determine, as best we can, if and how the two intersect and what are the implications for health philanthropy.

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**1996.** The year that the New York Yankees, showing little respect for the hosts of the Centennial Olympics, bested the Atlanta Braves four games to two to win the World Series. The year that *The English Patient* won nine Academy Awards, including best picture. The year that the play *Rent* won the Pulitzer Prize for drama, the rapper Tupac Shakur was gunned down, and Frank McCourt's *Angela's Ashes* was a runaway best-seller. In 1996, Russia and Chechnya signed a cease-fire agreement, a furor over "mad cow disease" broke out in England, and Israel elected Benjamin Netanyahu as its prime minister. That year, Americans lived through a four-month budget crisis that all but paralyzed the federal government. Later, Congress passed two major pieces of social legislation: Welfare Reform and the Health Insurance Portability and Accountability Act. The economy was strong and was showing the stirrings of the high-tech rally that led some analysts to predict that the Dow Jones average would reach 30,000. In November, America's voters elected Bill Clinton to a second term as president.

That year, both the public and health care professionals focused their attention primarily on managed care, AIDS, and tobacco. Ten years later, the major health issues had changed dramatically, bearing little resemblance to the issues that had captivated the nation only a decade earlier.

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**The Shift in Health and Health Care Priorities: 1996–2006**

Perhaps the signal health care event of the 1990s was President Clinton's health reform plan and its demise in 1994. The plan's failure unleashed an explosion of managed care plans. In 1996, 73 percent of the insured population was enrolled in a health maintenance organization or other form of managed care plan, up from 54 percent in 1993.<sup>1</sup> Much of the growth in managed care was in the for-profit sector. Health plans and hospitals vied to shed their nonprofit status and compete as money-making organizations. In the 1990s, for example, the Hospital Corporation of America, a for-profit corporation, became the nation's leading hospital chain by buying nonprofit hospitals throughout the nation. Many formerly nonprofit Blue Cross Blue Shield plans joined the stampede to become for-profits.

Two factors drove the rapid growth of managed care. The first was the need to cut the cost of medical services. The second was the desire for better coordination and monitoring of patient care. By integrating delivery systems and paying physicians on a per-patient (rather than a per-procedure) basis, managed care was supposed to offer an incentive to provide appropriate rather than excessive care and therefore save money. Calvin Bland, who in 1996 was the president and chief executive officer of St. Christopher's Hospital for Children in Philadelphia and is currently the chief of staff of the Robert Wood Johnson Foundation, recalls, "The whole focus was on hospital growth through mergers and acquisitions, enrolling people in HMOs, re-engineering hospital services, and cutting costs. It was a time of mergers and megamergers."

By 1996, managed care had succeeded in driving down costs somewhat. But to many, the price of cost-cutting was too high. Members of HMOs found that they could not get referred to specialists easily. They hesitated to visit emergency rooms for fear that their plan would not deem the visit a

true emergency and wouldn't cover it. And they were released from hospitals after only a brief stay—in the popular phrase of the day, patients were discharged “quicker and sicker.”

While 1996 might have been the high watermark of managed care, it also marked the point where the tide against it picked up force. Congress passed legislation prohibiting “drive-through deliveries,” where women who had given birth in a hospital were sent home the next day. Later in the year, Congress passed the Kennedy-Kassebaum bill—or, more formally, the Health Insurance Portability and Accountability Act—which prohibited managed care plans and insurance companies from denying coverage to people with a pre-existing medical condition who changed jobs.

By 1996, AIDS had become an American epidemic and an international calamity, attracting media headlines and drawing the attention of the health community. Between 1981, when the first case was reported, and 1996, more than half a million people over the age of 13 in the United States had contracted AIDS.<sup>2</sup> The number of new cases reported in 1996—68,000—was nearly double the number reported in 1992.<sup>3</sup> Yet there were signs of hope: many people at risk of contracting HIV were adopting safe sex practices, such as using condoms, and cocktails of antiretroviral drugs offered the prospect of converting AIDS from a death sentence to a chronic condition.

Smoking, too, was on the public's and the health community's mind. Well before 1996, Congress had required warning labels on cigarette packs, prohibited smoking on planes, and banned tobacco commercials on radio and television. By 1996, nearly 1,500 municipalities had enacted clean indoor air restrictions; attorneys general of forty-five states had filed or were preparing to file lawsuits against the tobacco companies; and it looked as if a master settlement agreement between the states and the tobacco companies (which would have settled the suits and committed the tobacco industry to pay significant amounts of money to the states and curtail its cigarette advertising) was within reach.

Although managed care, AIDS, and tobacco dominated the health news and the health policy journals in 1996, other health issues drew attention as well.

- Health insurance. Despite a booming economy and a tight labor market—conditions that one might suppose would have led to increased health insurance coverage—by 1996, the number of uninsured had reached 42 million, a matter of some, but not major, concern in Washington. The next year, Congress passed the State Children's Health Insurance Program, or SCHIP, which offered insurance coverage to poor children throughout the nation.
- Abortion and teenage pregnancy. Both of these reproductive health issues remained highly controversial and newsworthy.
- Drug abuse. Although substance abuse appeared to be less of a crisis than it had in the 1980s, the availability and use of illegal drugs remained a concern.
- End-of-life care. Sparked in part by a Robert Wood Johnson Foundation-funded study that found that physicians routinely ignored the wishes of dying patients, the care of patients toward the end of their lives was becoming an important health issue.<sup>4</sup>

*Fast forward to 2006.* Managed care has been largely transformed from a tiger to a pussycat. The restrictive systems that could, in theory, better manage patients' care and hold down costs were replaced by more open systems where cost saving was not the dominant feature.

Perhaps as a result of the changes in managed care, health care costs have gone through the roof. Premiums have risen by around 10 percent a year between 2000 and 2005, and fewer businesses—especially small ones—provide health insurance for their employees.<sup>5</sup> Sixty percent of firms offered their employees coverage in 2005, down from 69 percent in 2000.<sup>6</sup> When employers do provide health insurance coverage, premiums are increasingly borne by employees (in 2005, employees paid nearly \$1,100 more a year for family coverage, on average, than they did in 1996).<sup>7</sup> “The affordability of health insurance is a cyclical issue,” said Paul Ginsburg, president of the Center for Studying Health System Change. “In 1996, managed care had slowed the rise in health insurance premiums, and premiums had actually flattened out. By 2006, costs had risen again, and a lot of people were afraid they wouldn’t be able to afford health insurance premiums.”

At the same time, the number of uninsured has spiraled steadily upward, reaching nearly 46 million in 2005.<sup>8</sup> This upward spiral strains safety net providers such as public hospitals, free clinics, and community health centers, and it has serious health consequences as sick people delay seeking medical care until their illnesses become too serious to ignore and they then go to hospital emergency rooms for treatment. Health insurance coverage has emerged as the number one issue in labor contract negotiations. Medicaid, the backbone of insurance coverage for poor people, is in serious trouble as both federal and state governments seek to cut back their Medicaid budgets, which in many states have become unsustainable.

Even as the cost of medical care and the number of uninsured have risen to previously unthinkable levels, and underserved people living in inner cities and rural areas *still* have trouble finding a doctor, few in the federal government seem willing to address the issue of coverage. The only major change has been the addition of a prescription drug benefit to Medicare, which took effect on January 1, 2006, to the confusion of seniors baffled by a bewildering array of choices. Beyond Washington, some states, most recently Massachusetts, and cities have passed or are considering legislation to insure all their residents, but whether these programs are affordable remains a question.

Health care coverage now is a bitterly contested, often partisan issue in Washington. Some analysts and politicians, contending that health insurance should be a private sector responsibility, back “consumer-driven health plans” managed by insurance companies. Others argue that it is government’s responsibility to assure that all members of society have health insurance—that it is costly and inefficient to leave something as important as the nation’s health to market forces. The issue has become so highly politicized that few, if any, analysts see major change coming in the near future. “At least the system hasn’t fallen apart,” said John Lumpkin, former director of the Illinois Department of Public Health and currently a senior vice president at the Robert Wood Johnson Foundation. “Without a major transforming event, however, little is likely to happen at the federal level. At most, the system will undergo small evolutionary changes.”

Not only is access to health insurance precarious, but the public feels more vulnerable, its insecurity having been fed by September 11th, the anthrax attacks that followed the next month, and the threat of a bird flu pandemic. After September 11th, and the anthrax attacks, Congress appropriated funds to enable the governmental public health system to better prepare for a bioterror attack and, in 2006,

to strengthen the public health system's capacity to cope with an avian flu epidemic. But whether the nation's public health system—which the Institute of Medicine characterized as being “in disarray” in 1988 and again in 2002—is up to the challenge posed by the new threats is not known.<sup>9</sup>

While tobacco remains the nation's number one cause of preventable death, obesity may have eclipsed it as a health concern. The percentage of overweight and obese individuals rose from 45 percent in 1990 to 52 percent in 1996 (when the problem was barely discussed) to 66 percent in 2005. Obesity causes heart attacks, strokes, and diabetes, among other illnesses. It is increasingly prevalent in children, who are likely to grow up to be obese adults. “It is clear that childhood obesity is becoming a hot button political issue,” said Mark DiCamillo, director of the California-based Field Institute.

Obesity, smoking, unhealthy environments, high stress, and lack of health insurance hit the poor harder than the rich, and blacks and Hispanics harder than whites. Racial and ethnic minorities and people of lower socioeconomic class have far higher rates of heart attacks, strokes, some cancers, cavities, hypertension, and diabetes than do the white majority. While the nation was certainly aware of racial, ethnic, and class differences in health status in 1996, these were not a dominant issue. After Hurricane Katrina graphically exposed an American society of haves and have-nots, reducing racial and ethnic disparities in health moved somewhat higher on—though nowhere near the top of—the nation's policy agenda.

Ever since the Institute of Medicine's 1999 report, *To Err is Human* estimated that as many as 98,000 people die annually from illnesses contracted in the hospital, improving the quality of medical care has attracted more attention in the health policy community. The National Committee for Quality Assurance's work to develop quality standards for managed care organizations in the 1990s has expanded into wide-ranging efforts to measure quality and to hold health plans, hospitals, and physicians accountable for the quality of their services. The Center for Studying Health System Change's Paul Ginsburg said that the focus on quality is far different in 2006 from the focus of 1996: “In 1996, it was organizations like the American Medical Association arguing that restrictions on care would harm quality. Now there is a different perspective: quality refers to real failings in the way health care is delivered.” He added, however, “Quality is of concern to policy makers, but it hasn't crossed into the public's consciousness yet.”

The most significant changes in health and health care between 1996 and 2006 can be briefly summarized:

- In 1996, the changing health care system—restrictive managed care plans, for-profit health plans and hospitals, takeovers of local hospitals by big national chains, mergers of big health care systems—worried the public and policy makers. By 2006, the changes had run their course; employees tended to enroll in less restrictive managed care plans; and the concerns about managed care had largely faded.
- In 1996, costs appeared to be coming under control, mainly because managed care had clamped a lid on them. By 2006, they were out of control again, increasing at a steady 10 percent a year.

- In 1996, the number of uninsured Americans stood at 42 million, but lack of health insurance coverage was not attracting much attention. As a result of high premiums, in the 2000s, businesses cut back on buying health insurance for their employees. By 2006, the number of uninsured was rising at one million people a year, the number of uninsured individuals reached 46 million, and health insurance coverage was again back on the national political agenda.
- In 1996, Medicaid and Medicare hardly made the news. By 2006, both federal and state governments were looking for ways to cut back their Medicaid expenditures, which in some states had surpassed 30 percent of the annual budget. The enrollment problems with the Medicare prescription drug plan made the nightly news with fair regularity.
- In 1996, the governmental public health system was weak and ineffective, but hardly anybody noticed. By 2006, September 11th, the anthrax attacks, and the potential for a bird flu pandemic had raised awareness of the need for a stronger governmental public health system as a first line of defense against bioterrorism and the spread of infectious diseases.
- In 1996, AIDS was a national tragedy, very much on the public's mind. By 2006, though it had reached epidemic proportions internationally, changing sexual practices had reduced the incidence of AIDS in the United States, and pharmacological advances made it possible for HIV-positive Americans to live for many years.
- In 1996, almost nobody was talking about obesity as a national health problem. In 2006, newspapers, radio, and television bombarded the public, and awareness of obesity as a problem was high. At the same time, tobacco, a major issue in 1996, receded somewhat. (Even though tobacco remained the nation's number one killer in 2006, prevalence of smoking was at an all time low and youth smoking was the lowest in nearly three decades.)

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### The Robert Wood Johnson Foundation: 1996–2006

Foundations do not make a fresh start every year, every decade, or with every change of leadership. They are guided and bounded by their mission, their history, and their past grantmaking patterns. In both 1996 and 2006, the Foundation was well along on a course that had been set initially by its first board of trustees in 1972 and was guided by priorities that had been developing for decades. Working within those limitations, and cognizant of the social, economic, and political circumstances that affected the nation's health, the Foundation made two critical strategic shifts.

The first shift, made gradually in the early and mid-1990s under the leadership of the Foundation's president, Steven Schroeder, was expanding the Foundation's scope of activities to include not just *health care* but *health* as well. Influenced by a powerful literature demonstrating the social, economic, and behavioral determinants of health status and the experience of five years of tobacco-control and other substance-control programs, the Foundation in 1996 was poised to recognize publicly that addressing the root causes of poor health was as important as addressing the lack of access to medical care. The president's message to the board in January 1997, urged it to give *health* a priority equal to that of *health care*. By 1999, the Foundation had reorganized into two divisions, one devoted to improving health care and the other to improving health. The latter built on and provided a conceptual underpinning for the Foundation's grantmaking in areas such as addiction prevention and treatment, childhood obesity, and supportive housing for homeless people.

The Foundation's approach focused on several big ideas—access to care, chronic illness, substance abuse—and concentrated resources where they might be needed, even on short notice.

In contrast, the second strategic shift, which began shortly after Risa Lavizzo-Mourey assumed the Foundation's presidency in 2003, took a more targeted approach, honing in on a limited number of objectives whose impact could be measured quantitatively. With the adoption of an "impact framework," the Foundation established a "portfolio" of grants targeting 10 priority areas (later reduced to eight)—some of which sought to improve the behaviors, lifestyles, and conditions that lead to better health and others of which aimed at expanding access to, and improving the quality of, health care—and set specific, measurable strategic objectives for each of them. It also established three other portfolios: one that addressed issues affecting vulnerable populations, a second that focused on building human capital, and a third that sought to nurture new and promising ideas.

The change in the Foundation's thinking between 1996 and 2006 can be illustrated by examining three critical areas: encouraging healthy behaviors and lifestyles; expanding access to medical care; and improving the quality of care.

### **Encouraging Healthy Behaviors and Lifestyles: From Tobacco to Obesity**

In 1991, it was hardly a secret that smoking caused cancer, heart disease and stroke, among other fatal illnesses. When the Foundation took the step of making tobacco control a priority that year, it was able to do what it had done well in the past: help shape an emerging field.<sup>10</sup> Its grantmaking began somewhat timidly, with a relatively small grant to look at ways to reduce teenage smoking in four communities. Gradually, the Foundation became emboldened, and by 1996 it was in the process of developing a multi-pronged strategy to reduce smoking whose components were: (1) tobacco-policy research; (2) advocacy aimed at counteracting the tobacco industry's influence and informing policy change; (3) demonstration programs that put research into practice; (4) dissemination of tobacco-cessation standards; and (5) communications activities. In addition, the Foundation's president used the prestige of his office to keep the issue high on the nation's health agenda. Michael Pertschuk, co-founder of the Advocacy Institute and former chairman of the Federal Trade Commission, noted that the Foundation had taken on "the fundamental political dimension of the problem. It was a unique strategic intervention in the public health field that will serve as a model for years to come."<sup>11</sup>

From its experience in tobacco-control programs of the 1990s, the Foundation gained knowledge that it is applying to other areas. One lesson is the value of bringing to bear a broad range of approaches—what the health policy writer James Bornemeier called "a sustained flow of financial resources to all corners of the field."<sup>12</sup> Another is the importance of policy change. "The Foundation found a niche that government agencies could not fill, especially policy research and demonstration programs," said James Marks, senior vice president of the Robert Wood Johnson Foundation. "We learned that when a grant for services ends, the program often ends, but policy change persists." A third lesson is that a foundation can play a role beyond simply making grants. "Our prominence in the field meant that we were often a convener—a switchboard, as it were," Marks continued.

Recognizing the sustained drop in smoking rates and the need to address other threats to the nation's health, in 2003 the Foundation decided to gradually phase out its funding of tobacco-

control initiatives while working with its grantees to maintain the gains that they had made. By 2006, the foundation's tobacco-control activities had moved principally to supporting efforts to reduce smoking in public places and to decreasing the demand for tobacco.

Barely on the radar screen in 1996, obesity is, in 2006, a public health threat that has captured the public's attention. The Foundation came to embrace reducing obesity as a priority somewhat circuitously. In 2001, it made healthy communities and healthy lifestyles a priority area. Focusing first on encouraging physical activity, the Foundation awarded grants that helped communities become friendlier to walking, biking, and other forms of exercise.<sup>13</sup> By 2003, however, as obesity became a major public health issue, the Foundation made halting the upward trend in childhood obesity one of its strategic objectives, and added nutrition to the work it had been doing to promote physical activity.

Like tobacco in the early and mid-1990s, obesity is an emerging field whose direction the Foundation may help shape. The similarities between tobacco and obesity are unmistakable: both involve harmful personal behaviors and both fall hardest upon people of limited means. There are also differences: nicotine is an addictive substance, while foods have not been shown to be physiologically addictive; tobacco had a villain, while no such obvious heavy has appeared in the nutrition or physical activity areas; and while second-hand smoke aroused people whose health was affected by the smoking of others, there is no similar rallying point around obesity.

Building on the similarities and adapting the approach it employed in its tobacco-control initiatives, the Foundation is planning to use a broad range of approaches to reach the goal of halting the increase in childhood obesity by 2015. These include building the science base, funding pilot programs in schools and communities, producing information for the media and the public, convening activists, and providing information for policy-makers. The specific directions of the Foundation's approach toward childhood obesity are still emerging, and tangible national indicators of success or failure will probably not emerge for years.

### **Expanding Health Insurance Coverage: From State and Local to National Approaches**

Over the years, the Foundation has oscillated between two different approaches to expanding coverage for the uninsured.<sup>14</sup>

The first approach, an incremental one that tries to bring about change at the state and local levels, was dominant in 1996. In part, this resulted from the Foundation's role in health reform. In 1992 and 1993, as President Bill Clinton's plan to reform health insurance was being developed and debated, the Foundation and its grantees were a source of information on health policy. Foundation staff members helped organize a series of meetings with Hillary Clinton to help explain the proposals for national reform. Some people were critical of the Foundation for playing what they viewed as a partisan role. Stung by criticism that it had taken sides in the debate, the Foundation pulled back.



Instead of promoting national health care reform, it adopted instead a posture of encouraging incremental change at the state and community levels while also showing a willingness to support existing federal programs. Commenting on the Foundation's move from the front lines of the political debate, the Foundation's president, Risa Lavizzo-Mourey, said, "Up to the early 1990s, the Foundation had never been in the crosshairs of a political debate, even with its work in AIDS in the 1980s. We learned how politicized the issue of coverage had become and, for us, the importance of being nonpartisan. We also learned that we can be most effective if we are neutral conveners."

In 1996, the Foundation's efforts to help states and localities expand health insurance was characterized by a program called Communities In Charge. Looking to emulate an apparently successful program in the Tampa Bay area of Florida that raised the local sales tax in order to finance a managed-care plan for uninsured people, the Foundation was planning a program that would support fourteen communities' plans to provide insurance coverage to their uninsured.<sup>15</sup>

The Foundation was also able to support the federal government through a program called *Covering Kids and Families*<sup>®</sup>, which let parents of poor children in fifteen states know that their kids might be eligible for Medicaid and attempted to simplify the application and approval process. Shortly after the Foundation authorized funds for Covering Kids, Congress passed the State Children's Health Insurance Program, or SCHIP, that made health insurance available for poor children. Taking advantage of the new federal legislation, the Foundation dramatically increased its support of Covering Kids, expanded the program to all fifty states, and developed a major media campaign to accompany it.

The second approach was to promote action to expand health insurance coverage at the national level. By 2006, the pendulum had largely swung back as the Foundation recognized that major change, if it happens at all, is likely to come from Washington. "Incrementalism is the second best solution," said the Foundation senior program officer Nancy Barrand. "How can we settle for second best?"

The return of the pendulum began in 1999 when the Foundation convened a meeting of a group of Washington-based policy experts and activists from all over the political spectrum concerned with the problem of the uninsured. Called "the strange bedfellows," the group agreed on the need to cover the uninsured; it continues to meet and look for ways to do it. By 2003, the strange bedfellows meetings had led the Foundation to organize the first Cover the Uninsured Week—a large-scale public relations campaign designed to remind the nation that millions of people are uninsured and that the lack of insurance harms their health. Cover the Uninsured Weeks have been an annual event since then.

In 2006, one of the Foundation's strategic objectives is enactment of a national policy ensuring stable and affordable coverage for all by the year 2010. It does not endorse any single path toward reaching that goal, however. "While we know where we want to go—stable and affordable coverage for all—we don't take a position on how to get there," Lavizzo-Mourey said. "The issue is highly politicized, and there is no consensus on a solution. I doubt that there is even a consensus among our staff and board."

While many people give the Foundation credit for sticking with the issue, 20 years of Foundation attention to it appears to have yielded little tangible success. If the Foundation's work to expand health insurance coverage taught it to temper its expectations, its experience in a related area—cost containment—was positively humbling. In 1996, the Foundation was trying to reduce the cost of health care, but it found that in a trillion dollar-plus health economy, it had little leverage. “One of the lessons we internalized from the 1990s has to do with health care costs,” Risa Lavizzo-Mourey said. “We’ve come to understand what we can and cannot do. Here, the system is dependent on reimbursement. We’ve learned to avoid areas where we have few effective levers.”

### **Improving the Quality of Care:**

#### **From Scattered Programs to Systemic Change**

Without using the word “quality” as an objective, the Robert Wood Johnson Foundation was doing a great deal to improve the quality of care of people in 1996, especially the care provided to people with chronic illnesses. For example, it supported the National Committee for Quality Assurance, the National Quality Forum, the Institute for Healthcare Improvement, and *The Dartmouth Atlas of Health Care*.<sup>16</sup> And it developed programs to give chronically ill people the option of paying friends and relatives, rather than agencies, to take care of them;<sup>17</sup> to connect nursing schools and nursing homes in order to improve the quality of care provided in nursing homes;<sup>18</sup> and, most prominently, to improve the care given to dying people.<sup>19</sup>

In 1995, amid great fanfare, the Foundation released the disappointing results of a study it had funded called SUPPORT (the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment).<sup>20</sup> The findings from SUPPORT revealed that physicians and hospitals routinely ignored the wishes of dying patients and their families. In light of these discouraging findings, the Foundation decided to mount a campaign directed at improving the care that people receive toward the end of their lives. In 1996, staff members at the Foundation were preparing the campaign, which got under way the next year.

As in the case of tobacco control, the Foundation entered a field in which there was already a lot of interest and took a multipronged approach to shaping it—funding palliative care programs at major medical centers, medical and nursing curricula improvement, coalitions of advocates, articles in leading medical and nursing journals, and a Bill Moyers PBS series on end-of-life care called, *On Our Own Terms*, which was seen by an estimated nineteen million viewers. In 2003, as it was re-considering its priorities, the Foundation concluded that, like its tobacco programs, its end-of-life programs had largely achieved what they had set out to do, and decided to phase out its support. As of 2006, the Foundation had ended most of its end-of-life grantmaking, with the exception of the *Center to Advance Palliative Care*, which it continues to support in concert with other major funders.

By 2006, building on its work over the past decade, the Foundation had made improving the quality of care for people with chronic illness one of its strategic priorities. As one example, in 1996, the Foundation was supporting the Group Health Cooperative of Puget Sound, a Seattle-based health maintenance organization, in its development of a new model of providing high-quality care to people with chronic illnesses. This led to the Foundation's funding, in 1998, the *Improving Chronic*

*Illness Care* program that tested the chronic care model in a number of different locations.<sup>21</sup> Though the chronic care model requires a re-thinking of the way in which medical care is organized, by 2006, it was gaining increasing recognition as an effective way of treating people with a wide variety of chronic illnesses.

The Foundation has gone well beyond its stated goal of trying to improve quality of care only for chronically ill people, and, in practice, is trying to improve the quality of care of patients generally, whatever their medical condition. Between 2001 and 2006, it authorized at least seven major programs focused directly on quality improvement; commissioned Institute of Medicine reports on the topic; and created an eponymous team to oversee its quality improvement efforts. It has funded the work of the Institute for Healthcare Improvement, for example, to reduce medical errors. Moreover, the concern about quality infuses many of the Foundation's programs, such as its nursing and addiction prevention and treatment programs.

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## Conclusion

The Robert Wood Johnson Foundation's board and staff continually grapple with the question of how the organization can best fulfill its mission of improving the health and health care of all Americans—a question whose answer is complicated by the recognition that while the Foundation is a major force in health philanthropy, it is only a tiny player in a trillion dollar-plus health economy.

In 1996, the Foundation's approach was articulated by three broadly ambitious goals—increasing access to care, improving the care of people with chronic illness, and reducing the harm caused by substance abuse. To achieve them, it gave the health side of its mission as much importance as the health care side and devoted substantial resources to comprehensive approaches to addressing a few critical health issues such as smoking and end-of-life care.

In 2003, the Foundation developed an impact framework, which continues to guide its programming in 2006. The impact framework takes a more targeted approach—establishing measurable short-term, medium-term, and long-term targets for eight priority areas and allocating funds in an equitable manner among them. At the same time, the Foundation continues to give high priority to improving the health care workforce, finding better ways to provide care to the underserved, and seeking innovative new ideas.

Risa Lavizzo-Mourey has observed, “As a result of the changes that began in the mid-1990s, we were forced to question our approaches to social change.” The impact framework articulates the Robert Wood Johnson Foundation's approach to social change in the health and health care fields in 2006, just as the three goals did in 1996. Neither approach is better or worse, right or wrong. They are, however, different, and represent the ways that the Foundation's leadership, working within the framework of the institution's history and past priorities, seeks to achieve its mission.

The Foundation's approach to social change is based in part—and only in part—on its attempt to be responsive to the external environment. A foundation that is overresponsive to changing public opinion risks becoming faddish, yet one that ignores the concerns of the public and policy-makers risks being out of touch. Striking a balance requires a deft touch.

Over the years, staff members and trustees have learned that some of the Foundation's most effective programs have been those in which the Foundation has entered fields as they were emerging and then shaped the direction they took. The most obvious examples are tobacco control and end-of-life care in the 1990s, but earlier programs—nurse practitioners and emergency medical services, for example—bustress the point. Some of the Foundation's current programming—for example, strengthening the public health system and reducing childhood obesity—builds on issues that are now viewed as critical to the nation's health and well-being. These are issues that emerged between 1996 and 2006 that concern the public and have captured its attention and whose direction the Foundation may be able to affect.

However, entering emerging fields and working to shape them explains only part of the Foundation's strategies. While the Foundation has learned that it needs to be responsive to the external environment, it has also learned that it must remain true to its principles, even when they may not be in sync with prevailing wisdom. Some of its current objectives, therefore, represent areas that are not high on the public agenda. Improving the quality of care and reducing disparities did not resonate loudly with the public in 1996 and still do not. But they are important to the Robert Wood Johnson Foundation. Making issues such as these a priority gives the Foundation an opportunity to play a leadership role and to help make them more prominent. Or, simply, to promote values it believes are important for the nation's health.

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## Notes

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