

The Robert Wood Johnson Foundation: 1974–2002

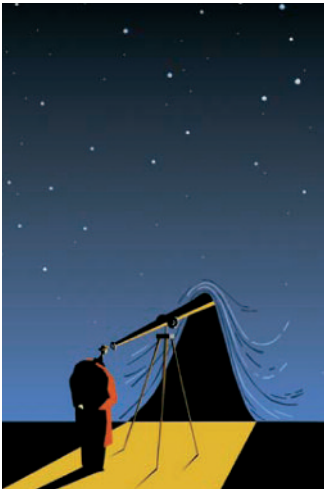
JOEL R. GARDNER



Robert Wood Johnson
Foundation

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Edited by
Stephen L. Isaacs and
James R. Knickman

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Editors' Introduction

Although the Robert Wood Johnson Foundation became a national philanthropy only 34 years ago, the institution's history and the personalities that have shaped it are important to an understanding of its current philosophy and principles. People often say that a philanthropy can change quickly—especially with the arrival of a new leader. While this has much truth in it, the past does in fact shape thinking and practice at the Robert Wood Johnson Foundation, just as it does in most organizations attempting to play a serious role in American life.

In Volume VIII of the *Anthology*, Joel Gardner, a writer and historian who has conducted oral histories and other historical research on behalf of the Foundation since 1991, and Andrew Harrison, the Foundation's archivist, told the story of the establishment and early years of the Foundation—years in which the Foundation was shaped by the founding chairman of the board, Gustav Lienhard, its first president, David Rogers, and a board that had many personal ties to the founder, Robert Wood Johnson.¹ This chapter by Gardner complements the earlier chapter and takes the Foundation through 2002, when Steven Schroeder retired and Risa Lavizzo-Mourey assumed the role of president and chief executive officer.

While many of the basic approaches to grantmaking that are still evident today—the national program structure, a focus on communications and evaluation, scholarship and fellowship programs, and the testing of new ideas through large demonstration programs—began during the Foundation's first three years, in subsequent years the fruits of these approaches to grantmaking appeared and new approaches were developed to meet changing times and priorities. In this chapter, Gardner weaves the personalities who shaped the Foundation, the impact of their leadership on the Foundation's strategies and programs, and the national environment that influenced the Foundation's grantmaking into a concise history of the Robert Wood Johnson Foundation.

1. Gardner JR and Harrison AR. "The Robert Wood Johnson Foundation: The Early Years." In *The Robert Wood Johnson Foundation Anthology: To Improve Health and Health Care, Vol. VIII*. San Francisco: Jossey-Bass, 2005.

A visitor to the Robert Wood Johnson Foundation offices turns off of U.S. 1 in Princeton, New Jersey, onto a curving, countrylike road and then into a small, tree-lined parking lot. The Foundation's new building, completed in 2001, rises into an almost bucolic landscape. The front doors lead into a tall atrium. To the left is a large portrait of Robert Wood Johnson himself—the man whose bequest has enabled the Foundation, over its 34-year existence, to assume and maintain leadership in the world of health philanthropy. A little beyond is the Foundation's mission statement, a direct descendant of the credo that Johnson developed for his company, Johnson & Johnson.

A photograph on one wall of the long hallway between the entrance and the information center shows David E. Rogers and Gustav O. Lienhard, the president and the chairman, respectively, of the Foundation in its earliest days as a billion-dollar institution. Rogers, the visionary president, looks off into the distance, as though imagining the next program, the next big grant. Lienhard gazes at Rogers, smiling, perhaps knowing that he holds the key to the philanthropic treasury.

Another photograph shows a frame house on Livingston Avenue in New Brunswick, New Jersey—the first home of the Foundation under the leadership of Lienhard and Rogers. The next photos show the first shovelful of earth turned, a cast of board and staff, and the Foundation's trustees, circa 1974, at the site that now houses the Foundation.

1972–1976

As the Foundation moved into its new home, it operated within its defined structure and within the goals and guidelines set in 1971 and 1972, the year that the Robert Wood Johnson Foundation became a national philanthropy. The board comprised mostly Johnson & Johnson colleagues and professional acquaintances of Robert Wood Johnson, who had headed the company since 1932. The staff consisted of experienced grantmakers and young enthusiasts under the aegis of Rogers, the former dean of the medical faculty at the Johns Hopkins University School of Medicine and one of the leading figures in American medicine. Lienhard, the chairman, was the linchpin between the board and the staff, the filter through whom ideas were passed to the board.¹

Lienhard saw himself as both inhibitor and enabler. He held staff members back from proposing grants that he felt the board would not approve, but at the same time, if he believed that an idea was worthwhile, he made every effort to persuade the board to support it. His partnership with Rogers created an equilibrium that enabled the young Foundation and its youthful staff to thrive. For program staff members, the greatest challenge was to create a multimillion-dollar program and design it so that Rogers and then Lienhard would support it.

Three objectives governed the Foundation's early grantmaking. They were designed to support a system of national health insurance that the Nixon administration and Congress were expected to establish. The three initial objectives were to:

- Expand access to medical care services for underserved Americans (which dominated the Foundation's early grantmaking).

- Improve the quality of medical care.
- Develop mechanisms for the objective analysis of public policies on health.

To carry out these objectives, the Foundation adopted three approaches: demonstration programs that tested ideas in a number of different locations; training and education of health professionals; and research, evaluation, and policy analysis.

Demonstration Programs

To reach its objective of expanding access to care, the Foundation relied primarily on large demonstration programs to test promising ideas in a number of locations. To administer its early demonstration programs, the Foundation adopted a model by which grants were managed by national program offices, often based in academic medical centers, and counseled by national advisory committees comprised of experts in the field.² This model enabled the Foundation to develop demonstration programs that were then evaluated, with the hope that the federal government would respond to successful efforts with additional funding.

The Foundation's first major national demonstration program was the *Emergency Medical Services Program*. A call for proposals, issued in 1973, described the outcomes the Foundation was seeking, the amounts and the number of the grants that the Foundation would fund, and the criteria that would be applied in the selection of grantees. A grant to the National Academy of Sciences provided support for administration, site visits, and evaluation. This program, which tested different ways of responding to medical emergencies in 44 different communities, laid the groundwork for the 911 call system that is ubiquitous today.³ With variations developed over the years, national programs based on the Emergency Medical Services Program model became the norm.

Training and Fellowships

The *Clinical Scholars Program* provided the template for the second approach—training programs.⁴ By selecting sites to provide training and then choosing scholars competitively, the Foundation was able to expand the scope of education in medicine and public health. The Clinical Scholars Program and its early companion, the *Health Policy Fellowship Program*,⁵ provided the model for other scholarship and fellowship programs most recently categorized under the rubric of “human capital.” These programs used national program offices to administer them and national advisory committees to select candidates. They provided training to health care professionals, primarily physicians, with the expectation that the graduates would play prominent roles in health policy or academic medicine.

Training and fellowship opportunities were a particularly appropriate way of increasing the number of minority physicians, who were more likely than majority physicians to practice in underserved inner city and rural areas.⁶ Scholarships for minority medical students (along with women and medical students from rural areas), a summer enrichment program for minority students in the College of Medicine and Dentistry of New Jersey, and institutional support for Meharry Medical College were among the earliest examples of the Foundation's efforts to address the issue. In the 1980s, the *Minority Medical Faculty Development Program* (renamed the *Harold Amos Medical Faculty*

Development Program in 2003) and the Minority Medical Education Program (now called the *Summer Medical and Dental Education Program*) eased the way for more members of racial and ethnic minorities to enter the field of medicine.

The Foundation used a wide range of approaches in carrying out a strong commitment to nursing—a field that Robert Wood Johnson cared deeply about and that he supported in his personal philanthropy. In its efforts to strengthen the nursing profession in the 1970s, the Foundation funded projects in different sites—especially hard-to-reach rural sites—to demonstrate the value of nurse practitioners and physician assistants in providing care to underserved populations. It supplemented demonstration programs with fellowship and scholarship programs, such as the Nurse Faculty Fellowships in Primary Care and the Clinical Nurse Scholars Program.⁷ The commitment has continued over the decades with a series of programs to strengthen nursing in hospitals and nursing homes, to improve the quality of home health care and nursing home aides, and to train a corps of leaders of the nursing profession.⁸

Research and Evaluation

That research and evaluation have been an important part of the Foundation's initiatives since the beginning should come as no surprise. Research was essential to the worlds of both Rogers and his closest associate, Robert J. Blendon—one, a doctor of medicine, the other, of science—and evaluation was important to the board members affiliated with Johnson & Johnson, who were accustomed to carefully evaluated clinical trials.

The demonstration model was most valuable if accompanied by data from the programs and analysis of that data. Moreover, policy was one of the three objectives first set forth by Rogers in the 1972 *Annual Report*, and funding policy implied funding research that could provide the justification for policy recommendations. By farming out evaluations to groups such as the RAND Corporation and Mathematica Policy Research, the Foundation sought to receive unbiased, methodologically sound, and credible reports on the programs it funded. In many ways, the Foundation's strong emphasis on evaluation brought a quantitative imperative that suited both the academics and the businessmen on the board, and broke new ground for foundations.⁹

Today, research and evaluation continue to play a vital role in the Foundation's activities. Members of the research and evaluation staff participate in the development of grants and follow them throughout the process. As initiatives for social change have replaced demonstration projects on the agenda, evaluations now focus less on results and more on learning opportunities.

New Jersey Grantmaking

The longest thread in the Foundation's grantmaking leads back to its commitment to New Jersey. It began in New Brunswick and Middlesex County, the home of Johnson & Johnson. Today the Foundation goes further, with a range of grants across the state, but it has also kept its focus on Robert Wood Johnson's hometown.¹⁰

It is not surprising that this category has survived; it has always been smaller than the larger objective or goal areas, but always in the balance sheet. After all, the board that led the Foundation in the early 1970s was virtually identical to that which had guided it in Johnson's lifetime, comprising among its 10 members, five Johnson & Johnson alumni, as well as a banker, a doctor, and a judge from the New Brunswick area. The board grew, adding more outside members over the years, but the Johnson & Johnson representation has remained strong, and the commitment to the New Brunswick area unwavering.

New Brunswick grantees that bridge the eras include the Kiddie Keep Well Camp for children with disabilities, the Salvation Army, and the Society of St. Vincent de Paul, but the Foundation also contributed to such urban revitalization projects as New Brunswick Tomorrow. The Foundation's grants helped drive the growth of the Robert Wood Johnson Health Network in New Brunswick, assisted the Center for State Health Policy at Rutgers, and established the *New Jersey Health Initiatives* program, now based in Camden, which is a competitive grant program for health and health care organizations within the state.

1976–1986

In 1976, Rogers announced the promotion of Leighton E. Cluff to executive vice president. Cluff, a longtime friend and colleague of Rogers, had joined the Foundation earlier that year as senior vice president to handle management and administration.

As the 1970s progressed, the likelihood of reform in the national health care system diminished, and in 1980 the staff and board revisited the Foundation's objectives. Rogers reported new objectives in that year's *Annual Report*. The first objective addressed access to health care and emphasized programs to expand access for the most underserved groups. The second objective addressed cost and stressed programs to make health care arrangements more effective and care more affordable. The third addressed chronic illness and focused on programs to help people maintain or regain maximum attainable function in their everyday lives.

Of all the concentrations of the Foundation, none has had a longer life, in one variant or another, than access to care. From its earliest days, the Foundation sponsored programs to expand insurance and delivery, to explore prepaid group plans, to promote primary care (or generalist) medicine, and to set up ambulatory care clinics. In the mid-1970s, it supported a program to improve dental care for the handicapped that changed the practice of serving disabled people;¹¹ primary care training programs for doctors and nurses;¹² regional perinatal service networks that were able to provide better care for premature and low-birthweight infants than individual hospitals could;¹³ and a program to improve the practice of medicine in rural areas by developing primary care group practices in remote communities. Rogers wrote in 1978 that the Foundation's grantmaking was "increasingly directed toward the remaining groups that continue to have problems getting care, especially residents of inner-city and rural areas, children of low-income families, and the low-income elderly."

Between 1982 and 1984, the Foundation began its long commitment to addressing the needs of the chronically ill. The Program for Hospital Initiatives in Long-Term Care (1982–1988) provided funds

for hospitals to develop comprehensive initiatives to meet the medical needs of the elderly, and the *Rural Hospital Program for Extended-Care Services* (1981–1987) established the concept of “swing beds,” which could be used for either long-term or short-term patients.¹⁴

Two programs begun in the 1980s, *Health Care for the Homeless* and *Community Care Funding Partners*, broke new ground. In collaboration with the Pew Charitable Trusts, the Foundation developed the Health Care for the Homeless Program (1983–1990), which brought attention to the needs of that underserved, and even ignored, population and served as the model for the Stuart B. McKinney Homeless Assistance Act, the primary federal law providing assistance to homeless people.¹⁵ Under the Community Care Funding Partners Program (1981–1997), the Foundation collaborated with local foundations to support small health centers serving indigent patients. With these two programs, plus a third, the *Interfaith Volunteer Caregivers* program (1983–1987) that supported interfaith coalitions of congregations whose members volunteered their services to help neighbors in need, the Foundation began to reach out beyond medical centers to a new audience of grantees: community organizations.

In 1983, the Foundation began to seek ways to address the AIDS epidemic.¹⁶ By 1986, two programs were up and running, one through the University of California, San Francisco, that replicated a community-based model of preventing the transmission of HIV and providing supportive services for HIV-positive people, and the other, aimed at children with AIDS, at the Albert Einstein College of Medicine in New York City. The first program, called the *AIDS Health Services Program* (1986–1992), provided the model for the Ryan White Comprehensive AIDS Resources Emergency Act, the federal law providing funds for AIDS education, prevention, and treatment. Later, Rogers was named vice chairman of the National Commission on AIDS.

From its earliest days, the Foundation committed itself to having a strong communications function. Working with Rogers and Lienhard, Frank Karel, who was named vice president for communications in 1974, essentially created a model of foundation communications. Lienhard, as Karel writes, wanted to “get the word out”—to share information with the field and the public about the programs the Foundation funded and what could be learned from them. But he wanted that word to be about grantees and not the Foundation itself.¹⁷ The Foundation’s staff continues to consider clear communications integral to helping its grantees promote better health and health care. Therefore, the Foundation invests substantially in building grantees’ capacity to develop communications strategies and in connecting grantees to policy-makers and opinion leaders who can help enhance their impact.

Lienhard’s health began to decline in 1984, and the board members began a quest for a successor chairman. While their first choice was a retired Johnson & Johnson officer, no one leaped forward to offer his services. In 1985, the board turned to Robert H. Myers, Jr., whose Washington, D.C. law firm had advised the Foundation on legal issues related to the tax code and to the disposition of assets. Though Myers lived in the Washington area, he agreed to spend weekdays in Princeton so that he could oversee the Foundation.

Shortly after Myers’s appointment, Waldemar Nielsen’s book *The Golden Donors*, the long-awaited follow-up to his first book, *The Big Foundations*, appeared. Since the publication of Nielson’s first study

of foundations, bequests had added a number of new members to the foundation world. For the Robert Wood Johnson Foundation, Nielsen provided reassurance that its programs and methodology passed his critical tests. He wrote, “In the clarity and ambitiousness of its purposes, in the intellectual power that has governed its strategy and grantmaking, in the social sensitivity and political skill by which its programs have been shaped, in the able and creative way in which its programs have been managed, and in the general qualities of integrity and independence that have characterized all it has done, the Robert Wood Johnson Foundation is the best of the big foundations today.”¹⁸

In November of 1985, David Rogers had a heart attack. He survived the attack, but, without Lienhard, he no longer had his strongest advocate with the board. In the fall of 1986, only months after *The Golden Donors* had heaped praise on the Foundation, the board provided Rogers a professorship named for his mentor, Walsh McDermott, at Cornell University Medical College and named executive vice president Leighton Cluff as the Foundation’s second president.

1986–1990

Lee Cluff first met David Rogers in 1949, when he accepted an internship on the Osler Service at Johns Hopkins Hospital while Rogers was an assistant resident there. Cluff remained at Hopkins, rising through the ranks to become professor of medicine and head of the Division of Allergy and Infectious Disease at the Johns Hopkins University, until 1966, when he moved to the University of Florida as professor of medicine and chairman of the Department of Medicine. During his tenure there, he promoted projects to serve the health and medical needs of the rural communities of central Florida.

Cluff immediately began to place his own presidential imprint on the Foundation. After seeking ideas from leaders in the health field from around the country, he suggested to the board that the Foundation expand the range of its grantmaking, most notably by focusing even more on community-based organizations. He also recommended that the Foundation support programs aimed at a wider variety of problems, including specific diseases and threats to health.

As a result, the Foundation adopted three broad goals—assisting the most vulnerable individuals, combating specific diseases of regional or national concern, and addressing broad national health issues and concerns—and 10 specific priority areas:

1. Infants, children, and adolescents
2. Chronic illness and disability
3. AIDS
4. Destructive behavior, including substance abuse and violence
5. Mental illness, an issue made more difficult by the era’s move to deinstitutionalize mental patients
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
10. The impact of medical advances

The priorities did not include access. Cluff wrote, “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.”¹⁹

One of the most important programs to emerge from the Cluff era was SUPPORT, the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment, which laid the groundwork for the Foundation’s later work with end-of-life issues. The study found that even after intensive training of nurses and physicians who cared for dying patients and counseling for family members, most Americans die in hospitals, often alone and in pain, after days or weeks of futile treatment, with little planning, and at high cost to the institution and the family.²⁰ Long after Cluff’s departure, the Foundation was hard at work to ameliorate the treatment of patients toward the end of their lives.

Cluff paved the way for his successor in other ways. By making substance abuse a priority, he set the stage for the Foundation’s later work to combat smoking. And his efforts to engage the issue of AIDS, along with other social and behavioral health problems, presaged the Foundation’s later reorganization into health and health care components.

The board had made clear to Cluff that his tenure was to be short. Myers stepped down as chairman of the board in 1988, to be replaced by Sidney F. Wentz, the former chairman and chief executive officer of Crum & Forster, a New Jersey-based insurance holding company. Cluff stepped down in June 1990, and the board appointed Steven A. Schroeder to succeed him.

1990–2002

Steven Schroeder brought to the Foundation an orientation and a way of doing business that differed from those of his predecessors. He was a Californian, for one thing, by temperament as well as birth, though edged by more than a decade in the East. A member of the prestigious Institute of Medicine who had impeccable academic credentials, Schroeder always maintained a commitment to clinical medicine.

Schroeder graduated from Stanford University and Harvard Medical School, then served two years as an epidemic intelligence officer with the Centers for Disease Control and Prevention. After a residency in Boston and various appointments at Harvard, he joined the faculty of the George Washington University Medical Center. He returned to the West Coast as an associate professor in the Department of Medicine at the University of California, San Francisco, where he founded and became chief of the Division of General Internal Medicine.

He arrived at the Foundation in 1990 as its third president, and had an immediate impact. His goal, Schroeder said, was social change, rather than simply grantmaking.²¹ He sought to consolidate the Foundation’s program objectives within a limited number of categories in order, as he wrote in the 1990 *Annual Report*, “to help the nation and its health care system identify and pursue new opportunities to address persistent health problems and to anticipate and respond to significant emerging problems.”²² This led to a restatement of the institution’s goals in July of 1990. The new goals were to:

- assure that Americans of all ages have access to basic health care.
- improve the way services are organized and provided to people with chronic health problems.
- promote health and prevent disease by reducing harm caused by substance abuse.

Reining in the cost of medical care, while not a stated goal, remained a principal concern.

Building upon its earlier work in the field, the Foundation began a vigorous campaign to reduce substance abuse, particularly smoking. In the 1992 *Annual Report*, Schroeder listed five main elements in that campaign: establishing substance abuse as the nation's leading health problem; improving prevention and early intervention; reducing demand through community initiatives; reducing harm caused by tobacco; and understanding the causes of substance abuse.

During Schroeder's tenure, the Foundation delivered nearly half a billion dollars in grants to combat tobacco use through policy research, publicity, advocacy, and demonstration programs.²³ The largest program was *SmokeLess States*, which, under the direction of the American Medical Association, funded state coalitions whose aim was to encourage tobacco control policies, such as prohibiting smoking in restaurants and raising the tax on cigarettes.²⁴ The Center for Tobacco-Free Kids, established in 1996, was created to serve as a counterbalance to the Tobacco Institute; it played an important and controversial role in the tobacco settlement negotiations.²⁵ The Foundation also has given continuous support to the public relations campaigns of the Partnership for a Drug-Free America. In addition to its tobacco control programs, the Foundation addressed the problem of youth drinking by establishing programs aimed at curbing alcohol abuse among college students and drinking by high school and even younger students.²⁶ It also sought to reduce drug abuse through community programs such as Fighting Back and through the advertising campaigns of the Partnership for a Drug-Free America.^{27,28}

Twenty years after the Foundation began its grantmaking based on the assumption that national health insurance was inevitable, the Clinton administration began to address the issue anew. In response, the Foundation undertook four Conversations on Health, in which Schroeder and a group of panelists, usually including Hillary Clinton and Secretary of Health and Human Services Donna Shalala, entertained comments and questions from grass-roots organizations and individuals. The Clinton health care reform initiative failed, and more than 10 years later, Conversations on Health and subsequent Foundation-sponsored television programs related to health care reform remain controversial. Schroeder and most health care professionals saw the activities as nonpartisan—a means of facilitating discussion. Republican politicians and some board members were less impressed, viewing the Foundation's role as having attempted to facilitate the Clinton plan. After that, the Foundation turned to incremental and targeted change.²⁹

One of those targets was the coverage of children. In 1997, the Foundation launched the *Covering Kids and Families*[®] program, at a projected cost of \$13 million, to inform low-income families of children in 15 states that they might be eligible for Medicaid. One month later, Congress passed the \$20 billion State Children's Health Insurance Program. The Foundation added \$34 million to the pot to help all states let low-income parents know that their children might be eligible for governmental

health insurance and to streamline the enrollment process.³⁰ The program was expanded in 2001 to cover both eligible children and eligible family members.

Building on the SUPPORT research on the care of dying patients, the Foundation developed a comprehensive approach to improving care toward the end of life. It funded, among other things, programs to expand palliative care in hospitals; revise medical and nursing textbooks; commission articles in professional journals; and organize coalitions to improve end-of-life care and encourage people to fill out living wills and other advance directives.³¹ It also funded a widely watched documentary by Bill Moyers, *On Our Own Terms*, that provoked a great deal of media attention and public comment.

In the 1990s, the Foundation expanded its *Local Initiative Funding Partners Program*, which reached out to community philanthropies,³² and initiated *Faith in Action*[®], a program based on the earlier Interfaith Caregivers program, which explored the possibilities of voluntarism through coalitions of faith-based congregations whose members provided services to homebound neighbors.³³

While the Foundation continued to provide major support to health policy research, perhaps the most important single health policy program to emerge during the Schroeder years was *Health Tracking*.³⁴ The immediate impetus was the chaos surrounding the entrance of managed care into the health care marketplace, marked by the dissatisfaction of both physicians and patients. Through a variety of studies, Health Tracking sought to follow and assess the changes wrought by managed care in terms of access, quality, and cost. To carry out Health Tracking, the Foundation established a new organization, the Center for Studying Health System Change, in Washington, D.C. Its reports and publications have contributed to a deeper understanding of the health care landscape, from Capitol Hill to local agencies.

Under Schroeder's 12-year leadership, the Foundation went through major changes. For one thing, the board of trustees diversified substantially with the inclusion of the first woman, the first African American, and the first person of Latin-American descent. For another, Schroeder redesigned the Foundation so that both health and health care could be addressed equally. Indeed, the transformation of the Foundation into a bicameral institution was the most momentous change in the Foundation's history, in several ways.

First, by making health and health care equivalent, the Foundation departed from its earlier pattern of grantmaking, which had concentrated largely on health care. Steven Schroeder and former Foundation senior vice president J. Michael McGinnis offered the following comment on the meaning of the change: "for much of its first 20 years the Foundation attended predominantly to the medical care element of its mission...By contrast, it neglected the non-medical care factors that influence a person's health, such as choices about smoking, diet, sexual behavior, and physical activity, as well as environmental exposures and other factors—the health dimension of its mission."³⁵ The shift provided a rationale for funding programs in substance abuse, tobacco, and other social and behavioral areas.

Second, it led to a restructuring of the staff and a reshuffling of personnel. Staff members had to choose whether to concentrate on either health issues or health care issues. The Foundation was

reorganized in 1999, with one senior vice president heading the health group and another heading the health care group.

Third, the new structure recognized the Foundation's size, as is appropriate for an institution with \$9 billion in assets. With a staff of upward of 200 working in 11 strategic areas, as well as national program directors, the Foundation was a long way from the small, flexible, generalist staff that had marked its earliest days. To fit the growing staff into an appropriate workplace, Schroeder then undertook the expansion of the Foundation's offices, which today dwarf its predecessor (which was incorporated into the new building) in nearly every way.

Schroeder is the first to admit that the changes he wrought were possible only because of the economic boom that accompanied his presidential years. The rising corpus—from \$2.9 billion in 1990 to \$8.7 billion in 2000—made some sort of restructuring inevitable. Schroeder's first concept—to split the Foundation into four separate, smaller, program-focused foundations—won little support from the board, which preferred to maintain its unified structure. The next idea—health and health care vice presidents under a realigned management structure—was more palatable to the board.

Sidney Wentz retired as board chairman in 1999, and the board appointed Robert E. Campbell, retired vice chairman of the board of directors of Johnson & Johnson, to succeed him. The board also named Schroeder as both president and chief executive officer.

As Schroeder announced his retirement, which took place at the end of 2002, and looked back on his tenure, he shared his thoughts about his successes and failures in the Foundation's *Annual Report* and in a chapter of a book called *Just Money*.³⁶ Though he was frustrated at the continuing rise in the number of the uninsured and in the failure of the Foundation to effect major changes in coverage, he looked back proudly at its—and his—impact on the fight against smoking, on programs related to end-of-life issues, and on the expansion of coverage of children through state governments.

A Conclusion of Sorts

Thanks to a few dedicated men and women, the Robert Wood Johnson Foundation has accepted the challenge of its founder to invest, in effect, in health and health care in the United States. With his colleagues from Johnson & Johnson closely guarding his legacy, and with an energetic and far-seeing staff daring to dream about what might be, the Foundation reached out in ways large and small to reconfigure the landscape.

The largest task—making decent and affordable health care available to all—remains undone. The Foundation's first assumption, that President Richard Nixon would do for national health care what he did with China, turned out to be incorrect. Moreover, its ability to alter the way in which medicine is practiced in the United States was limited by economic and other factors far beyond its control. Hospitals and their staffs grew and shrank. Physicians became generalists, and then they did not. There was a nursing shortage, and then there was not, and then there was again. Managed care seemed so promising, if only doctors and patients would allow themselves to be managed.

But then there are all those programs to serve the underserved in ghettos and rural areas; AIDS patients and the homeless; children and the elderly. The anti-smoking initiatives have surely saved lives, and end-of-life care is vastly improved.

Seventy years after Robert Wood Johnson set up the Johnson New Brunswick Foundation in order to donate some parkland, he would look on the foundation that bears his name with pride, but also with cognizance of the force that drove him during his lifetime: there is always more to accomplish.

Notes

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