Editors' Introduction

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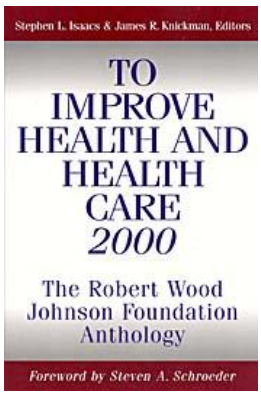
Robert Wood Johnson Foundation

Editors' Introduction, excerpted from the Robert Wood Johnson Foundation Anthology:
To Improve Health and Health Care, 2000



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The Robert Wood Johnson Foundation became a national philanthropy in 1972 with a mission of improving the health and health care of all Americans. Starting with an endowment of $1.2 billion bequeathed by General Robert Wood Johnson, the former chairman of Johnson & Johnson, the Foundation has, since then, made grants totaling $3.3 billion, and its assets have grown to $8.4 billion, making it the nation's fourth-largest foundation.

In its earliest years, the Foundation gave highest priority to ensuring that Americans had access to basic health care. Since 1991, the Foundation has broadened its goals to include improving services for chronically ill people and reducing the harm caused by substance abuse. In 1998, the Foundation awarded $358 million to 999 grantees and contractors for demonstration projects, research, training and communications activities that further these three objectives.

Several years ago, senior executives at the Foundation began looking for new ways to let the public know what it was doing–ways that would complement its *Annual Report* and its newsletter, *Advances*, and that would be more accessible than the articles about Foundation-funded programs appearing in scholarly journals. As a result, two new publications were initiated. The first is end-of-grant reports. These are analyses of past programs by specially trained outside writers. They are posted as Grant Reports and National Program Reports on the Foundation's Web site (www.rwjf.org).

The second is the *Robert Wood Johnson Foundation Anthology* series entitled *To Improve Health and Health Care*. It is an attempt to offer the public interestingly written yet analytically strong in-depth analyses of a cross section of the Foundation's programs. In a way, we are striving to produce a new kind of publication–one that has both literary and scholarly distinction and that, moreover, is useful to policy-makers and practitioners. The trick to producing this kind of book, as we are learning, is to combine the literary ability of outstanding writers, the analytical power of outstanding thinkers, and the experience of outstanding doers.

As Steven Schroeder noted in his Foreword, with three volumes having been completed it is time to begin drawing lessons from the Foundation-funded programs that are examined in the *Anthology* series. With this in mind, we have reviewed each of the chapters published to date. We were not looking for idiosyncratic lessons applicable only to specific programs. These are, in fact, quite plentiful, and are found in just about every chapter of the *Anthology*.

Nor were we looking for programs that succeeded, although these too are found in abundance in the *Anthology* series. They include *Emergency Medical Services* (2000 *Anthology*), nurse practitioners and physician assistants (1998–1999 *Anthology*), and school-based health clinics (2000 *Anthology*), to give a few examples. Nor did we look for programs that did not achieve their expectations, although there are lessons to be drawn from SUPPORT (1997 *Anthology*), *All Kids Count* (1997 *Anthology*), and *Strengthening Hospital Nursing* (1998–1999 *Anthology*), among other programs.

Rather, we looked for broad lessons that would help readers understand the context of social change, develop better programs, replicate successes, anticipate challenges and overcome obstacles. In the *Anthology*, we discuss four lessons that emerge from the initial volumes of the series. These are (1) the need for flexibility in a rapidly changing system dominated by market forces; (2) the need to reconceptualize demonstration projects as the federal government reduces its support of social programs; (3) the limits of systems reform; and (4) strategies for building new fields to address pressing issues. Although these are not the only lessons that can be drawn from the experiences set forth in the *Anthology* series, they mark a beginning. We will no doubt return to the topic in our introductions to future volumes of *To Improve Health and Health Care.*

THE NEED FOR FLEXIBILITY

The extent to which managed care and market forces have affected the financing and practice of health care is widely recognized. Their effect on philanthropy is not as widely appreciated. The rise of managed care has changed the course of many Foundation-funded programs, causing unexpected disruptions and forcing grantees to show great ingenuity just to keep their programs afloat. As Irene Wielawski noted in her chapter on the Reach Out program (1997 *Anthology*) in Lancaster County, Neb., the arrival of Medicaid managed care nearly gutted efforts to recruit volunteer physicians to serve poor rural patients, whereas in Sacramento, Calif., managed care left doctors little time or incentive to volunteer. A program called *Strengthening Hospital Nursing*, designed to increase the role of nurses in hospitals, began just as the economics of managed care led to widespread lay-offs of nurses and shifting their duties to less qualified aides. In the 1998–1999 *Anthology*, Tom Rundall, David Starkweather, and Barbara Norrish wrote, "As managed care techniques were adopted… hospitals sought to cut costs by…employing fewer high-cost registered nurses…. The importance of larger environmental forces on hospital decision making cannot be ignored." In their chapter on the health care workforce (1997 *Anthology*), Stephen Isaacs, Lewis Sandy and Steven Schroeder concluded that the Foundation was slow to recognize the shift in the leadership of health care from the medical

community to corporations and business concerns.

The mercurial nature of the health care system presents both challenges and opportunities for a philanthropic organization and its grantees. In the case of its workforce programs, the Foundation responded by offering training opportunities to professionals outside of university academic medical centers–its usual source of trainees. In the case of the *Reach Out* program, it meant recognizing and responding to what Wielawski calls "the imperatives of the bottom line." In some cases, as Lisa Lopez observes in her chapter in the 1998–1999 *Anthology*, it meant providing incentives to HMOs to offer primary care for their members with chronic illnesses.

Whatever the specific mechanism, programs must contend with the changes brought about by managed care and market forces and with the shifting group of players who enter and leave the field. The cautionary tale implicit in the *Anthology* papers is to avoid one-dimensional and rigid approaches–even at the risk of disrupting programmatic or research plans. The moral emerging from the stories of program adaptations that weave their way through many chapters is that flexibility and creativity are essential. Programs appear to require continuous fine-tuning over time.

THE NEED TO RETHINK DEMONSTRATION PROJECTS

What do you do with demonstration programs when the audience for whom you have been demonstrating is no longer there? This is the question facing the Foundation and other philanthropies now that the gaze of practitioners, policy-makers, and the voluntary sector has shifted from the federal government and national solutions toward local resources, state governments and private enterprise.

During its early years, the Foundation built its reputation on large multisite demonstration programs that tested different solutions to common problems. The expectation was that the federal government would adopt successful approaches and expand the effort throughout the nation. What better way, after all, to foment social change than to demonstrate workable solutions to problems and convince the federal government to bring its sizable resources to bear?

To a certain extent this worked. The federal government took over the funding of nurse practitioner and physician training, as Terrance Keenan notes in his chapter for the 1998–1999 *Anthology*. The example of the Foundation-funded *Health Care for the Homeless Program* led to the passage of the 1987 McKinney Act, which provides federal dollars to improve homeless people's access to health care

services, as Debra Rog and Marjorie Gutman observe in their chapter in the 1997 *Anthology*. Similarly, the Foundation's early efforts to promote an emergency medical system influenced the development of a national EMS system whose early years were largely underwritten by the federal government, as discussed in Digby Diehl's chapter in this volume of the *Anthology*.

As a rule, however, the federal government can no longer be expected to adopt successful programs. Since the 1980s, it has tried to shift to states, localities, business, and the nonprofit sector its traditional responsibility for providing services for those in need. Perhaps the major exception in the 1990s is children's health insurance, which is discussed in Marguerite Holloway's chapter in this year's *Anthology*.

With little likelihood that the federal government will adopt and expand even successful programs, the Foundation has moved to a more nuanced approach. While not entirely abandoning its traditional demonstration programs, the Foundation has shifted its focus to strengthening coalitions at the state and local levels and to offering assistance to state and local government officials. The hope is that states and localities will pick up effective initiatives. A number of chapters in the *Anthology* series examine the Foundation's efforts to work at state and local levels.

Paul Brodeur for example, in his chapter in this volume of the *Anthology*, traces the history of the Foundation's efforts to promote school-based health services. In 1986, the Foundation funded a large demonstration called the *School-Based Adolescent Health Care Program*, designed to attract the attention of the federal government. Its successor program, *Making the Grade*, strives to increase the availability of comprehensive health care for school-age children by reorganizing state and local financing policies. In a related vein, the Foundation, beginning in 1991, funded *State Initiatives in Health Care Reform*, a program designed to help states plan and develop insurance-market and Medicaid reforms. Beth Stevens and Lawrence Brown examined the State Initiatives program in the 1997 *Anthology*. Working at state and local levels, the Foundation funded programs to develop affordable assisted-living facilities in rural areas, discussed by Joseph Alper in this volume, and to improve services in adult day centers, analyzed by Rona Henry and her colleagues in this volume. There is little expectation of future federal government involvement, although programs might be replicated with funding from nonfederal sources.

In an age of declining trust in and expectation from the federal government, working at state and

local levels is a logical–and perhaps the only viable–strategy. Although these programs promise greater sensitivity to local circumstances, more latitude and control for the participants, and the ability to tap local knowledge and ingenuity, they also can involve parochialism, factionalism and competition among organizations fighting for resources. Stevens and Brown (1997 *Anthology*) remind us that health reform at state and local levels is essentially political in nature. They note that "foundations, and those who evaluate their work, should recognize that discussion, better staffing, technical aid, and diffusion of knowledge can tidy up the messiness of health politics only so far… whether foundation programs end up 'working' or not depends largely on the funder's sagacity in reading the capacity and political personality of state applicants."

Thus, working at state and local levels brings to philanthropy a new set of challenges: understanding the relevant political, cultural and social environment; reading the local situation for signs indicating how best to bring about change within that environment, and carefully choosing those actors most likely to achieve the desired results. In this regard, partnerships with local foundations, such as those described by Irene Wielawski in her chapter on the *Local Initiative Funding Partner* program in this volume of the *Anthology,* can provide national philanthropies with an additional set of eyes and ears they might not have otherwise.

THE LIMITS OF SYSTEMS CHANGE

Systems-change projects attempt to rationalize fragmented or unresponsive health care delivery systems to better serve the needs of clients. The problem was succinctly described by Susan Allen and Vincent Mor in their chapter on services for chronically ill people in Springfield, Mass., that appeared in the 1997 *Anthology:* "Current systems of care provide not a protective blanket of health and social services but, rather, patchwork quilts, with the size and the adequacy of each individual quilt depending on the number and the size of the patches for which one is eligible." For a foundation whose annual grant giving amounts to less than $400 million in a trillion-dollar-plus health economy, the systems-change strategy is appealing. It requires a relatively small outlay of resources–compared with initiating an entirely new service program–and has the potential to bring about far-ranging improvements in care.

Seductive as reforming service delivery systems may be as a way to leverage limited philanthropic resources, it is not a panacea. As we learn from a number of *Anthology* chapters, systems-change programs have their limitations.

First, although logical in theory, they are hard to bring about in practice. In their analysis of a program to reform systems of housing and health care for homeless people in the 1997 *Anthology*, Rog and Gutman conclude, "Systems changes–enduring and far-reaching reformulations or modifications in the structure of a system–were rare in the *Homeless Families Program*…. Although ambitious, the efforts of the program to reform systems were in many ways overpowered by the complexity of the systems that needed restructuring." Moreover, the complexity of systems change can lead to unforeseen and unintended consequences. The warning of Stevens and Brown about the messiness and factionalism of local and state politics, referred to earlier, is also relevant here. What is logical organizational reform for one person may be loss of turf for another.

Second, reforms of the organization and administration of health care systems may not, by themselves, be enough to improve patient outcomes. This was the conclusion reached by Leonard Saxe and Theodore Cross (1998–1999 *Anthology*) and Howard Goldman (2000 *Anthology*). They found that the Foundation-funded programs had succeeded in integrating mental health services but that the mental health of the patients had not improved. This led them to argue that the quality of services being delivered is as important as the means of delivering them. As Howard Goldman writes in this year's *Anthology*, "service system integration was necessary but not sufficient to improve individual level outcomes." He was referring to mental health services programs, but the comment is applicable more broadly.

NURTURING FIELDS THAT ADVANCE THE FOUNDATION'S PRIORITIES

Over the years, the Foundation has nurtured–and in some cases created–fields that further its mission and goals. Generalist physicians, nurse practitioners, minority health professionals, and tobacco policy research are examples. In the process, certain patterns have become evident about how fields become established and develop. Although these are not models to be followed slavishly, they do illustrate how the process of social change can be enhanced.

An initial step in the process is identifying and supporting a core group of leaders and potential leaders. Often they are found in academia. The Foundation has a history of funding fellowship programs for advanced training in a field. This approach not only gives individuals greater credibility but also provides greater visibility to the university department or group with which they are associated. It may also establish the field within mainstream graduate education. For example, to develop the field of primary care (general) medicine, the Foundation funded a variety of fellowship

programs and supported the establishment of the *Society of General Internal Medicine.* The fellowship programs included, among others, the *General Pediatric Academic Program* in the 1970s and the *Generalist Physician Faculty Scholars* in the 1990s. In their analysis of the Foundation's support to academic medicine in the 1998–1999 *Anthology*, Lewis Sandy and Richard Reynolds conclude, "Although fellowship programs are expensive, supporting bright young people early in their career may be a more effective institutional change strategy than direct institutional grants."

To promote the field of primary-care nurse practitioners in the 1970s and 1980s, the Foundation embarked on a similar course by funding the *Nurse Faculty Fellowship Program* and the *Clinical Nurse Scholars Program.* Terrance Keenan notes in his chapter for the 1998–1999 *Anthology* that the graduates of the former program "made a decisive difference in the ability of nursing education to secure the future of the nurse practitioner field." Similarly, in an effort to increase the number of minority physicians, the Foundation established a national program whose purpose was to increase the number of full-time minority faculty members in nonminority medical schools.

A second step is building research capability and developing a body of relevant research. Take the Foundation's efforts to build a credible field of research in substance abuse. After adopting a goal in 1991 of reducing the harm caused by substance abuse, the Foundation supported the creation of the new field of tobacco policy research. In their chapter for the 1998–1999 *Anthology*, Marjorie Gutman, David Altman and Robert Rabin note that the research contributed in very concrete ways to the efforts to develop effective tobacco control policies and gave the field credibility. They state, "In the past 10 years the field of tobacco policy research has literally blossomed. There is now a critical mass of established researchers."

The wide range of research the Foundation was willing to support further advanced the field. Tobacco policy research expanded to substance abuse policy research. A network of researchers was set up to study the causes of addiction to nicotine. The Foundation, in partnership with other institutions, undertook the daunting task of trying to integrate the work of social and behavioral science researchers with that of biologists, chemists, neuroscientists and other researchers to find answers to questions that would lead to more effective strategies for reducing tobacco use. Nancy Kaufman and Karyn Feiden describe this effort to promote "transdisciplinary" research in this volume of the *Anthology*.

A third step is funding a variety of other programs that will advance the field. This includes training, advocacy, policy analysis, coalition building, establishment of professional societies, demonstrations, conferences and communications. As Robert Hughes points out in his chapter on the Foundation's adoption of a substance abuse goal (1998–1999 *Anthology*), the Foundation funds large national programs such as Fighting Back, which fosters community coalitions; smaller programs such as the *National Spit Tobacco Education Program* (see Leonard Koppett's chapter in the 1998–1999 *Anthology*) targeted to more specific issues; organizations such as the Center on Addiction and Substance Abuse, which attempts to pull together all aspects of the field; and a wide range of other activities. In a sense, the Foundation wraps its arms around a field as it attempts to nurture it.

A fourth element—not as specific as the first three—is long-term commitment. Bringing more underrepresented minorities into the health care workforce is one example. The Foundation's earliest programs, authorized in 1972, were medical school fellowship programs for minorities, women and rural inhabitants. Its commitment to increasing the number of minority physicians has not flagged since that time. The Foundation has funded programs to help qualified minority college students compete successfully for acceptance by medical schools, to provide research grants to minority professors with appointments at nonminority medical schools, and, more recently, to identify and guide qualified minority high school students who might be interested in becoming health care professionals.

Although it may be able to focus attention on an area, give its practitioners credibility and fund programs, the Foundation has neither the resources nor the power to establish a field by itself. Sometimes, success is a matter of timing and riding the crest of greater forces in society. In the best of circumstances, a foundation will be slightly ahead of the curve and able to influence the development of a field. This was the case, for example, with emergency medical services and nurse practitioners; the Foundation stepped in just as society—including the federal government, with which the Foundation collaborated closely—was embracing the fields. On the other hand, the Foundation worked since its inception to promote generalist medicine, bucking the trend toward specialization for many years. Only since managed care—with its emphasis on primary care—came to dominate health care delivery in this country did the trend toward medical specialization abate. Yet the Foundation's efforts were not without fruit; they helped seed the field so that medical schools were prepared for the changes that occurred in the 1990s.

Similarly, the Foundation, often in collaboration with the Association of American Medical Colleges, has been striving to increase the number of minority health care workers. Its efforts have met with some success. However, the dominant forces in society are going in the opposite direction at the moment. Even though it is sailing against societal winds, the Foundation, following its approach to generalist medicine, has continued to fund programs increasing the opportunity of minorities to become health professionals. Wind conditions may shift. Perhaps more important, this is how a foundation can advance its values, take a long-term perspective, and become a genuine public trust.