

The Robert Wood Johnson Foundation: *The Early Years*



BY JOEL R. GARDNER AND ANDREW R. HARRISON

Chapter Seven,
excerpted from The Robert
Wood Johnson Foundation
Anthology:

**To Improve Health
and Health Care
Volume VIII**



Edited by
Stephen L. Isaacs and
James R. Knickman

Published 11/2005

Editors' Introduction

A number of chapters in the *Robert Wood Johnson Foundation Anthology* series have attempted to demystify the practice of philanthropy by examining the internal workings of The Robert Wood Johnson Foundation.¹ This chapter, written by Joel R. Gardner, who, as a consultant, has been doing an oral history of the Foundation, and Andrew R. Harrison, who serves as the Foundation's archivist, recounts the early years of The Robert Wood Johnson Foundation—from 1936 through 1975.

Gardner and Harrison begin with a capsule biography of Robert Wood Johnson, who, while he was head of Johnson & Johnson, gave generously to local charities and established a small foundation for his philanthropic activities in the New Brunswick, New Jersey, area.

Johnson died in 1968, leaving just about his entire estate to the Foundation. When the will was probated, in 1972, The Robert Wood Johnson Foundation emerged as the nation's second-largest philanthropy. Gardner and Harrison capture the political circumstances into which the new and greatly expanded Foundation was born, and bring to life the early thinking about philanthropy among the first generation of Foundation staff, led by its first president, David Rogers. They discuss the ways in which early priorities and grantmaking strategies were reached between 1972 and 1975; how the concept of National Programs developed; and how program evaluation and communications became integral components of The Robert Wood Johnson Foundation's approach to grantmaking.

Why focus on early history? In addition to improving our understanding of the logic of grantmaking even today at The Robert Wood Johnson Foundation, the early history can provide useful lessons for new foundations that face philosophical and organizational challenges similar to those which confronted a fledgling Robert Wood Johnson Foundation more than thirty years ago. As the philosopher George Santayana wrote, "Those who cannot remember the past are condemned to repeat it."

1. See Hughes, R., "National Programs: Understanding The Robert Wood Johnson Foundation's Approach to Grantmaking." *To Improve Health and Health Care*, Vol. VIII: *The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 2005; Schapiro, R. "A Conversation with Steven A. Schroeder." *To Improve Health and Health Care*, Vol. VI: *The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 2003; Navarro, M., and Goodwin, P., "Program-Related Investments." *To Improve Health and Health Care*, Vol. V: *The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 2002; McGinnis, J. M., and Schroeder, S. "Expanding the Focus of The Robert Wood Johnson Foundation: Health as an Equal Partner to Health Care." *To Improve Health and Health Care 2001: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 2001; Karel, F. "Getting the Word Out: A Foundation Memoir and Personal Journey." *To Improve Health and Health Care 2001: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 2001; Knickman, J. "Research as a Foundation Strategy." *To Improve Health and Health Care 2000: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 2000.

In a small two-story house at 142 Livingston Avenue in New Brunswick, New Jersey, The Robert Wood Johnson Foundation began its transition from a locally oriented philanthropy to the nation's leading grantmaker in the health field. Through most of the twentieth century, New Brunswick was a company town, and the company was Johnson & Johnson, one of the world's largest manufacturers of health care products. The town is also the home of Rutgers University, New Jersey's state university, and the Robert Wood Johnson medical complex of hospitals and teaching institutions. From the moment that the first Robert Wood Johnson, who founded the company with his two brothers, Mead and James, set foot in New Brunswick in 1885 and decided to establish a plant there, the town and the company have lived in symbiosis, caring and providing for each other.

It was in New Brunswick that Robert Wood Johnson married for the second time. From this marriage, he had three children, including, in 1893, Robert Wood Johnson II. Young Robert attended Rutgers Preparatory School, but when his father died in 1910, he chose to enter the family business rather than attend college. By that time, the company was providing 90 percent of cotton and gauze bandages worldwide, exported in its own steamships. By that time, too, Mead had left the company to start his own enterprise, and James succeeded to the presidency. Robert moved in with his Uncle James and worked his way up from the mill floor to the executive suite. He was appointed a director of the company at the age of twenty-one, second vice president four years later, president and general manager in 1932, and chairman of the board in 1938. Because the company was vitally concerned with the delivery of health care, he visited hospitals worldwide; he also served terms as president and chairman of Middlesex General Hospital—now the Robert Wood Johnson University Hospital—in New Brunswick.

Johnson married Elizabeth Dixon Ross, of New Brunswick, in 1916, and their wedding was the social event of the year. They moved into Bellevue, an estate in Highland Park, and their son, Robert Wood Johnson III, was born in 1920. While living in Highland Park, Johnson became involved in local politics and served a term as mayor while he was still in his twenties. His marriage broke up in 1930, and his wife and child remained at Bellevue, while he relocated with his new wife, Margaret, to Morven, in Princeton, which later became the governor's mansion. With his third wife, Evelyne, or "Evie," he moved in the 1940s to Longleat, an estate south of Princeton.¹

From any perspective, Robert Wood Johnson was a singular individual. Though he was a firm believer in the corporate system, he promoted policies of employee support and empowerment that were radical for their time. He fought to maintain employee wages as a way of reinflating the economy during the Depression, and he developed a company credo that is a model of corporate enlightenment. During the Second World War, he was first a colonel and later a brigadier general, charged with running the Smaller War Plants Corporation, a position that the Washington columnist Drew Pearson called "the most difficult, undesirable job in government."² Though Johnson lacked a university education, his book, *Or Forfeit Freedom*, won the Book of the Year award from the American Political Science Association in 1948.

The Johnson New Brunswick Foundation and The Robert Wood Johnson Foundation: 1936–1967

Robert Wood Johnson’s first major foray into philanthropy was the Johnson New Brunswick Foundation, which was incorporated in 1936 for “charitable purposes in and about the city of New Brunswick and the County of Middlesex.” The Foundation’s Board included his brother, J. Seward Johnson, along with prominent members of the New Brunswick community. As its first grant, made in December 1936, the Foundation donated 130 acres of land along the banks of the Raritan River in Highland Park to the County of Middlesex for use as a public park. In 1946, the Foundation gave twenty-two additional acres to the county for park space.

During the Depression and the Second World War, the Johnson New Brunswick Foundation was dormant. It had just \$475 in its bank account. After the war, however, Johnson began to build the Foundation. In 1948, he contributed two thousand shares of Johnson & Johnson stock, announced to the Board of Trustees that his gift represented the first of his planned annual donations to the Foundation, and arranged for the company to make a gift of \$10,000.

The Foundation initiated its long-term commitment to New Brunswick’s Middlesex General Hospital and St. Peter’s Hospital with grants of \$5,000 to each in 1948. Four years later, at Johnson’s request, the Foundation removed the geographic restriction that had limited it to Middlesex County so that it could begin to fund projects and institutions throughout New Jersey while maintaining its primary focus on the New Brunswick area. In addition, the Board approved a name change to The Robert Wood Johnson Foundation.

During this period, Johnson focused on strengthening the Board, bringing in Johnson & Johnson executives such as Philip Hofmann, the company’s president, Gustav Lienhard, its chief financial officer, and Robert Dixon, its general counsel. He passed the chairmanship of the Board to Judge Klemmer Kalteissen. Norman Rosenberg, a local surgeon with ties to the company, added medical expertise. Seward Johnson left the Foundation to pursue his own philanthropic interests, but Robert Wood Johnson III served for ten years as a Board member, including terms as vice president and president.

Finally, it was during this period that the Foundation’s grant priorities took shape. Three areas of interest emerged: hospitals and health care; scholarship support, primarily in health care; and community service programs with a special focus on the indigent.

Approximately 65 percent of the Foundation’s grant funds went to support hospitals and health care, primarily in New Brunswick. For example, the Foundation awarded \$25,000 to Middlesex General Hospital for the purchase of a diagnostic x-ray machine and \$27,000 to St. Peter’s Hospital to buy equipment for its radiology department. Beginning in 1963, Johnson urged the Foundation to focus more attention on improving hospital management and nursing care, encouraging it to make grants to attract more people to the nursing profession and to improve the education of nurses.

The Foundation’s second major interest was educational scholarships for medical, dental, nursing, and pharmaceutical students who came from low-income backgrounds. It awarded a quarter of its grant funds in the form of scholarships.

Some 10 percent of the Foundation's grant funds were directed to the third of the Foundation's priorities: assistance to community agencies and to the indigent, particularly young people. The New Brunswick YMCA and YWCA, Boys Scouts, Girls Scouts, Walter D. Matheny School (a residential facility for children with cerebral palsy), the Francis E. Parker Memorial Home in New Brunswick, the B'nai Brith Hillel Foundation, and Christ Church of New Brunswick all received donations from The Robert Wood Johnson Foundation.

**Transition from a Local to
a National Philanthropy:
1968–1971**

Robert Wood Johnson II died on January 30, 1968. At the time of his death, The Robert Wood Johnson Foundation had a net worth of more than \$53 million through its ownership of Johnson & Johnson stock. Having provided for his family earlier through a series of trust funds, Robert Wood Johnson bequeathed his company stock, then valued at \$300 million, to the Foundation. It took three years to probate his estate, during which time the value of the stock increased to more than a billion dollars.

Shortly after Johnson's death, the group of men closest to him began, at his request, to plan the future of his Foundation. They set up a policy committee and called in experts in the field of health care to assist them in this ambitious undertaking. Even as plans for a greatly expanded Robert Wood Johnson Foundation were being drawn up, Congress was working on a tax reform act that would transform the nature of American philanthropy. Congress was moved to action by a series of events that it considered to be a flouting of the tax-exempt status enjoyed by private foundations. Members bristled at what they saw as the Ford Foundation's involvement in politics, and they were outraged by California's Irvine Foundation's and other foundations' holding enormous amounts of valuable land and other property and therefore sheltering themselves both from paying taxes and from making philanthropic grants. As a result, the 1969 Tax Reform Act included provisions that curtailed political activities on the part of foundations, prohibited the awarding of many direct grants to individuals, limited the amount of stock a foundation could hold in any one corporation to 20 percent, and, most important to Johnson's brain trust, required foundations to pay out each fiscal year an amount equal to a certain percentage of their assets (eventually settled upon at 5 percent).

Working to set up the structure of what would soon become the nation's second-largest foundation, the policy committee, overseen by the Foundation's Board of Trustees, concentrated on the composition of a new Board and the direction that the Foundation would take. The two obvious choices for Board chairman were Hofmann, the chief executive officer of Johnson & Johnson, and Lienhard, then chairman of the company's executive committee. Lienhard, closer to retirement, left the company and became chairman of the Foundation's Board of Trustees. The Board that Lienhard led drew heavily on Johnson & Johnson executives: Dixon, Hofmann, and Lienhard, as well as Wayne Holman, Jr., and Paige L'Hommedieu. For the first time, it included an outside member of national prominence, William McChesney Martin, chairman of the Federal Reserve Board from 1951 to 1970. Rosenberg, Leonard F. Hill, a New Brunswick banker, and Judge DuBois Thompson, who replaced former Board chairman Kalteissen, rounded out the roster of Trustees.

In May 1971, the policy committee made two critical decisions that affected the grantmaking of The Robert Wood Johnson Foundation: first, that the Foundation's grants would have a national focus; second, that its primary purpose would be "to contribute to the advancement of health care in the United States." It recommended that the Foundation's programs and projects encompass university medical centers, hospitals, college training centers, and professional associations throughout the country while continuing to support health and social service programs in the New Brunswick area. It determined that no grants would go to support general endowments, core administrative costs, medical research, or capital facilities.

Beginning in March and concluding in December 1971, the estate of Robert Wood Johnson transferred to the Foundation 10,204,377 shares of Johnson & Johnson stock. The new Robert Wood Johnson Foundation opened its doors in December of 1971 with \$1.2 billion in assets and a federal requirement that it pay out approximately \$45 million in grants in 1972. By way of comparison, the earlier Foundation had paid out \$4.4 million in its entire thirty-four years of existence. Since under the 1969 Tax Reform Act the Foundation could no longer make the kinds of grants it had been making to individuals, it scrapped its program of direct student scholarships. Finally, despite Robert Wood Johnson's wish that the Foundation's Johnson & Johnson stock remain intact, the Trustees realized that to comply with the Tax Reform Act and to meet the legal payout requirement, they would be obliged to sell some of the Foundation's shares in Johnson & Johnson.

The house on Livingston Avenue was suddenly much busier. The *New York Times* announced on December 6, 1971: "In one stroke, this philanthropic enterprise has become the second wealthiest foundation in the country, led only by the Ford Foundation." That night, apparently seduced by the lure of such riches, a burglar broke into the house. As Lawrence Foster recounts in his biography of Johnson, "The day after the story appeared, this author visited Lienhard at the Foundation office on Livingston Avenue with a draft of the *Annual Report* on grants made that year. As he approached the rear entrance of the parking lot, two workmen were rehandling the door, which had been ripped from its hinges. Lienhard was agitated. 'Some crazy jerks read in yesterday's paper that the Foundation was receiving \$1.2 billion,' he said, 'and last night they broke in here trying to find it.' With a glimmer of satisfaction, he added, 'The only thing of value here was a roll of stamps.'"³

Philosophy, Programs, and People: 1972–1975

Lienhard recognized that major national grantmaking, \$45 million worth, was vastly beyond the scope of the Board and staff that had overseen the Foundation up to that point, but he also believed that he and the Board would bring fiscal expertise to the venture, thus freeing the future president to concentrate on grantmaking.

Recruiting a New President and Staff

On the day that Lienhard revealed the Foundation's bounty, he also announced the Board's selection of a president. The choice was the result of a national search for an individual whose background and reputation would permit the Foundation to assume a leadership role quickly in health care philanthropy. The Board selected a man who seems in retrospect to have been bred for the position.

That person was David E. Rogers. A former professor and chairman of the Department of Medicine at the Vanderbilt University School of Medicine, Rogers was, at the time of his hiring, dean of the medical faculty and professor of medicine at the Johns Hopkins University School of Medicine, vice president (medicine) of the Johns Hopkins University, and medical director of the Johns Hopkins Hospital. While at Vanderbilt, he had engaged the medical school in the struggle for integration, and during his tenure at Johns Hopkins he oversaw the development of health care delivery systems serving minorities and the needy in Baltimore.

Rogers was a man of vision, strength, and compassion—attributes that he quickly imprinted on The Robert Wood Johnson Foundation. There is a photograph of Lienhard and Rogers that hangs in the Foundation building today, showing Rogers gazing into the distance, away from the camera lens, while Lienhard's eyes are focused squarely on him. Rogers was to be the visionary, and Lienhard would watch him every moment.

To carry out his vision, Rogers called upon mentors, colleagues, and protégés. His secretary of state, so to speak, was Walsh McDermott, whose official title was special adviser to the president. McDermott, who had, among his other accomplishments, earned an Albert Lasker Award for his work in the drug therapy of tuberculosis, had retired as Livingston Farrand Professor of Public Health and chairman of the Department of Public Health at New York Hospital–Cornell Medical Center. He brought the credibility of his medical experience to the Foundation, but his warmth and social skills are even more strongly remembered by his colleagues from those days.

Rogers recruited Robert Blendon, whom he had known at Johns Hopkins. At the time Blendon joined the Foundation, he was special assistant for policy development in health and scientific affairs to the assistant secretary and undersecretary of the federal Department of Health, Education and Welfare. Blendon's gift was creating programs out of Rogers's visions.

Rogers also reached out to the foundation world. From the Carnegie Corporation of New York, he invited Margaret Mahoney, who had worked in health care and health sciences education there. From the Commonwealth Fund, he brought in Terrance Keenan, who combined experience in health programming with a public information background, as well as nine years of work on the staff of the Ford Foundation. Together, Mahoney and Keenan provided a grounding, a sense of how things could and do get done. Both have gone on to enormous renown in the field of philanthropy, Mahoney as the first woman president of a major foundation, the Commonwealth Fund, and Keenan, who recently retired from The Robert Wood Johnson Foundation, as one of the great authorities on health and health care philanthropy.

Setting Grantmaking Priorities

The first task was to develop a perspective, not only to fulfill the mandate of the Tax Reform Act and part quickly with \$45 million in grants but also to lay out a plan of attack that would enable the Foundation to have an impact on the problems confronting the American health care system. Rogers estimated that the nation would spend \$80 billion on health care in 1972. The Robert Wood Johnson Foundation's payout represented less than 1 percent of that amount. He saw the

Foundation as providing seed money for new programs and ideas, and hoped to arouse public consciousness by legitimizing work in neglected health fields and by motivating the public sector to assume responsibility for providing health care services. Rogers told a 1975 symposium that he and the staff agreed on a few basic guidelines: to select outcome rather than process, to limit their work to a few basic problems, to address only areas with the potential for successful human intervention, to support projects with reasonable national visibility, and to time the Foundation's efforts to coincide with a national willingness to take action.

Earlier, in the Foundation's 1972 *Annual Report*, Rogers enunciated a broader set of what might be considered founding principles. "Recognizing that The Robert Wood Johnson Foundation's resources represent the largest single source of private capital to support new efforts in the health field, we sought wide counsel to help us decide where our funds might be put to work most effectively," he wrote.

We have studied previous foundation triumphs and failures. We have held conferences with a number of the best minds working on broad problems in health. We have had discussions with our colleagues in medicine and other health professions, and with the staffs of many of the decision-makers in government who are working to develop effective legislation in health. We have also consulted with those who are users of health services, studied much of the available literature, and looked at the economic, social, and political scene in which we will operate. And we've contemplated—a rare privilege in our world.

Rogers recognized as well that, unlike most foundations, The Robert Wood Johnson Foundation had the resources to underwrite large-scale field tests of new ideas, not just single experiments; to pull together large numbers of groups to work on complex regional and national problems and issues; to build fields, such as primary care and emergency medical services, by surrounding core activities with supporting ones that bolster them.

Pointing to the gap between biomedical technology and the delivery of service, Rogers cited "pressing basic national problems in health," including difficulties in obtaining simple office or ambulatory medical care, especially in rural and poor urban areas; the escalating costs of medical care; qualitative inequities in the health system because of inadequate evaluation; strengthening the human caring and supportive functions of medicine; and coordination of policy planning for health and medical care. In response, Rogers continued, "the Trustees and the staff have selected for our initial effort, the encouragement of institutions or individuals who are attempting to restructure the American health delivery system to make effective care more available for nonhospitalized patients." The Foundation would focus initially on three areas: improving access to medical care services for underserved Americans; improving the quality of health and medical care; and developing mechanisms for objective analysis of public policies on health.

"It is our hope that we can be effective, wise, and compassionate in interacting with those in our society seeking to better the human condition," he concluded. "We have, as an overriding belief, the conviction that human ingenuity, if given the chance, can invent practicable ways of moving toward the goals we have defined as our own—and giving that chance, in our judgment, is the appropriate and privileged role of a private philanthropic institution."

The first area of focus, improving access to medical care for underserved Americans, meant identifying, developing, and expanding the delivery of ambulatory care services. Rogers believed that the lack of a dependable primary care system represented the most pressing health problem confronting the American people. From low-income, inner-city residents and the rural poor to more affluent populations, too many Americans experienced problems in obtaining access to primary medical care. Many communities lacked adequate out-of-hospital services. Moreover, the trend toward physician specialization was leading to a shortage of generalist practitioners.

This thinking led the Foundation to establish emergency medical response systems,⁴ to promote the study of generalist medicine,⁵ and to support new types of health providers, such as nurse practitioners and physician assistants.⁶ Increasing access to care also was the rationale for scholarship programs for minority and women medical students and medical students from rural backgrounds. Between 1972 and 1975, the Foundation provided more than \$50 million to forty-eight academic medical centers to improve the delivery of, and train professionals in, ambulatory medical care.

The second priority, improving the quality of care, signified ensuring that patients received proper treatment and preventive health services. For example, the Foundation funded Georgetown University to develop a methodological tool that would measure the quality of diagnostic and follow-up care that patients received. It also attempted to improve quality by strengthening the capacity of young physicians to be better able to improve the health care system. It took over the *Clinical Scholars® Program* from the Commonwealth Fund and the Carnegie Corporation in 1973. This program, initiated several years earlier at five medical schools—Case Western Reserve, Duke, Stanford, Johns Hopkins, and McGill—sought to enable young physicians to complement their clinical skills with training in such nonbiomedical disciplines as the behavioral, management, and social sciences. The Clinical Scholars Program continues to thrive today.⁷

The third goal, improving public policy, indicated support for research into health care policies. To achieve this goal, the Foundation engaged a number of organizations to initiate centers for the study of health policy or to evaluate existing policies. It commissioned the influential *Mendenhall Report*, which confirmed the shortage of generalist physicians and indicated that 20 percent of Americans received primary care from a specialist physician; a study by the Center for Health Administration Studies at the University of Chicago that found that 24 million Americans did not have reasonable access to medical care; and a report by the Brookings Institution—carried out by Karen Davis, who later became president of the Commonwealth Fund—on the effects of government programs aimed at improving health access to medical care for the poor.

Establishing a System for Making Grants

The grantmaking process began with a small staff—Rogers, Blendon, Mahoney, Keenan, and McDermott. Their ideas, as well as ideas received from their broad contact base in the field, provided the basis for further discussion and proposals. “I wanted smart, idealistic people who were fully informed, comfortable with controversy, and who could sit around a table and disagree profoundly with one another, without taking it personally,” Rogers said later. Lienhard played a vital role in the process; he could enable the easy passage of a proposal at the Board level, but he also required

convincing. “Walsh would describe to Gus why a project was important, and Gus would then take it to the Board members,” Blendon recalls. “We never lost anything at the table, but probably 50 percent of our suggestions never got that far because of Gus’s opposition.”

The specter of the Ford Foundation loomed over the foundation world in those days, partly because it was the nation’s largest foundation and partly because of the question of staff size. Lienhard and the Board wanted to avoid what they saw as Ford’s bloated staff structure. They wanted a staff as lean as possible and overhead as low as possible, with a concentration on getting dollars into the field. In principle, this led to two approaches that would guide the Foundation through much of its first two decades. First, it meant that large grants were preferable to small ones; a small staff simply couldn’t handle a large volume of small grants. Second, it brought about a model of grantmaking—which continues today—in which a relatively small Foundation staff was augmented by outside consultants and where administration of National Programs was delegated to National Program Offices located outside of the Foundation.⁸

Interestingly, the notion of a small, efficient staff arose in part from a study prepared for the Ford Foundation in 1949. Anticipating the receipt of 90 percent of the shares of Ford stock, the Ford Foundation had commissioned a study to determine how it could transform itself from a local philanthropy to a national one. As reported in the *New York Times Magazine* in 1984, “One of the committee members, Don K. Price, submitted, in writing, his suggestions as to how Ford might be reorganized: keep the staff small, he wrote, and the number of grants large by turning over the programs to experts who would manage them outside the foundation.”⁹ Ford ignored his suggestions, but Price later shared his suggestions with Rogers, who adopted many of them. To do so, he drew on his major constituencies: hospitals, medical educators, and medical institutions large and small.

The Robert Wood Johnson Foundation started where Price left off and developed a structure for external administration that became known as the National Program model. Under this model, the Foundation was able to use the services of outside program directors with specialized expertise by reimbursing their home institutions for the cost of satellite offices and staff time devoted to administering the Foundation’s programs. The Clinical Scholars Program provided a prototype and an ideal test case. John Beck, former chairman of medicine at McGill, moved to San Francisco and opened an office, funded by the Foundation, from which he could administer the program. While he interacted closely with Foundation staff members, Beck managed the program, working directly with the five funded institutions.

The *Emergency Medical Services Program* was the first to employ a variety of features that came to characterize the National Program model.¹⁰ It solicited proposals, using a *Call for Proposals* to announce that forty to fifty grants of up to \$400,000 would be awarded. The *Call for Proposals* described what would be expected of grantees and the criteria by which applications would be evaluated by a national advisory committee of experts in the field, and the Foundation engaged the National Academy of Sciences to provide program administration.¹¹ Overseeing the program was assistant vice president Blair Sadler, an attorney who, with his twin brother, a physician, had helped develop Yale University’s trauma program into a national resource. The program’s success—as demonstrated by the federal government’s picking it

up—confirmed not only the potential of the National Program model but the efficacy of demonstration projects.

In 1972, the Foundation relocated to a plain and unimposing building in Princeton University's Forrestal Center, in a complex that had housed particle physicists and a linear accelerator. The new offices reflected Rogers' idea about how a foundation should present itself to the public. Most foundations featured lush carpeting and mahogany-paneled walls; Rogers rejected that image. He believed that lavish buildings intimidated potential grantees and siphoned off money that could go to social causes. He did not want the Foundation to appear as a place of wealth and ostentation. Staff and visitors alike had to travel up and down a cement staircase to get to the Foundation's second-floor offices, arrayed along a hallway with cinder-block walls and indoor-outdoor carpeting over a concrete floor. "We took great pride in our humble surroundings," an early staff member wryly observed.

The move from New Brunswick and the commitment to a national scope did not diminish the Foundation's commitment to support New Jersey and the community that was so important to Robert Wood Johnson himself.¹² Primarily through grants to Middlesex County Hospital and St. Peter's Hospital, but also through grants to smaller agencies such as the Society of St. Vincent de Paul of Highland Park and United Community Services of Central Jersey, the Foundation maintained its concern for the charities that it had supported for decades. Reporting to the Board in May 1972, the staff recognized the Foundation's "special obligation" to the New Jersey community and proposed to address it broadly. It recognized the possibility that the state, with its dependence upon New York and Pennsylvania and its concomitant smaller medical community, might offer an opportunity to develop experimental programs. At the same time, given the paucity of other philanthropic resources in the state, it expressed a willingness to address the needs of New Brunswick and the surrounding communities.

Integrating Evaluation and Communications

Above all, the staff was writing its own scenario for the development of Foundation programming. Nowhere was this more evident than in the development of evaluation and communications programs. In both, the Foundation set out to break ground, to adopt approaches that were new to the field.

Rogers was poetic in his description of evaluation in the 1973 *Annual Report*, evoking, not inappropriately, the *Odyssey* and the *Aeneid*:

So much for the vessels we have helped to send down to the sea this year. We have indicated some of the rocks and shoals which concern us, and have detailed some of our initial efforts to become wiser advisors. Whether the vessels we have encouraged to embark will safely make port we do not know. Perhaps in attempting to facilitate change this is all that can be done—to launch the ships and after eight to ten years look to see which ones made the trip successfully. But in our increasingly priority conscious world this passive approach would be irresponsible, and we must try to evaluate their journeys.

More prosaically, Rogers then admitted that program evaluation could not "yet be classified as a science." Still, if he was clear that the collection of data was essential to the understanding of what

the Foundation was doing, he also understood that the staff would be creating its own models. “We fully recognize that we have no well-tested prescription for this exercise but we have chosen some ways to start,”¹³ he said.

Rogers separated evaluations into three categories, each responding to different questions. At the simplest, the first level, the question was, “How well was the task carried out by those who conducted the program?” This, he argued, was useful internally but less so in the health professions, because it did not address the substantive issues of what the task was and what was its impact on the field.

Thus, the second level, which asked, “Did a particular program change the way individuals or institutions acted after the program was in place?” In this case, he said, the answer was useful to the community that the Foundation served, the national community of health professionals, but did not address how the Foundation carried out its programs.

At the third level, evaluations responded to the interests of “those groups and institutions which play a dominant role in the formulation of the nation’s health policies and who often make the decisions regarding the flow of new resources to any social welfare field.” So the questions were most focused on outcome: “Would additional expenditures of money to reproduce a particular program improve the welfare of people generally? Did it improve people’s lives?”

Rogers enumerated the pitfalls as well. Change might not be immediate, and therefore not evident in the evaluation. Most programs would lack the critical mass to draw meaningful conclusions. Most institutions lacked the resources to carry out the second- and third-level evaluations. Evaluators must be sure to avoid premature evaluation, but would be better served by eight- to ten-year timeframes. Finally, objective measurement was often in fact quite subjective.

Nonetheless, Rogers declared the Foundation’s intention to move forward. “Perhaps with the innocence of the novitiate, we have now indicated how a start is to be made on evaluation of programs we have encouraged,” he said. “Each of these efforts, and those which will follow, represent the first steps of a new foundation trying to discharge its obligations in a responsible and responsive fashion.”

The same *Annual Report* lists three evaluations of Foundation programs: a three-year study of the emergency medical response program by the RAND Corporation; an evaluation of the student-aid programs by the National Planning Association; and an analysis of a program to train dentists in the care of the severely handicapped, by the Educational Testing Service.

The Foundation’s evaluation function not only took root within the Foundation but also enabled academic practitioners to break new methodological ground and encouraged other foundations to hire staff members with expertise in analysis and measurement, as well as outside consultants with the skills to carry out appropriate evaluations of programs and their outcomes.

Rogers first presented to the Board a proposal for a public affairs and public information program in April 1973. “As we complete fifteen months of operation,” he said, the Foundation “is beginning to assume a satisfactory professional form...We are well housed in comfortable quarters, we have put

together a small but first-class professional staff which is viewed with respect in the foundation world and by those in medicine and the academic community. We have developed an administrative format which permits us to process grants in an orderly and well-organized fashion.”

What the Foundation needed next, he continued, was to enhance its ability to communicate with the public and to “articulate the purposes which have moved us into certain sectors” by creating a public affairs and information program that was integral to the Foundation. The person selected to run the program would have a seat at the grantmaking table, Rogers proposed, and would “participate fully in the discussion of policy, the selection of areas of focus, and the consideration of proposals that we plan to support.”

The person selected, Rogers continued, “should have broad experience in planning in public affairs and knowledge of organization and management of a public information staff. It would be helpful if he has had experience with academic institutions. He should have under his direction the responsibilities for building a small core staff with special skills in the communicative sciences and science writing.” Frank Karel was the Foundation’s choice. His background fit perfectly with Rogers’ description, and he ended up transforming the way in which foundations think of communications. Karel, a journalist with a specialization in science, had moved from the *Miami Herald* to the world of health and medicine. His résumé included stops at Johns Hopkins, the National Cancer Institute, and the Commonwealth Fund.

Karel’s guiding principle, which Lienhard embraced, was that the Foundation should speak through its grantees.¹⁴ “This concept has been our communications compass for more than a quarter of a century, and has emerged as one of the core values of the Foundation,” he wrote. This, along with the value placed on information by the Foundation, was underscored by including a bibliography of selected books, articles, and other information by our grantees in the 1976 *Annual Report*—a practice that has been broadened to include their work on the Web, video, data tapes, and audiovisuals, and continued to this day.¹⁵ Over time, from these first insights, the Foundation pioneered the concept of information as a foundation asset and communications as the tool for putting this asset to work in advancing its mission, to improve health and health care.

Summary

In the *Annual Report* for 1975, Rogers summed up the work of the Foundation’s first four years. “Put quite simply, helping groups to try new experiments which may contribute to better health for Americans remains our basic commitment,” he wrote.

We can assist those who are preparing people for new careers in medicine or the delivery of medical care to those not now receiving it. We can encourage the development of ways to determine whether the country has a system of acceptable quality. We can help create broader awareness of the public policy issues involved. We can attempt to stay with our programs long enough to determine their promise and to evaluate and report their impact...However, improvements come slowly in any complex system, and we are but a small part of it. Nonetheless, we are encouraged by the efforts being made by the many working in the field, and we continue to be challenged by the unusual opportunity afforded us to help some of those who are busily engaged on the front lines.

His words are as true today as they were thirty-three years ago, when the leadership of The Robert Wood Johnson Foundation first contemplated the billion-dollar bequest from its founder and decided to devote its assets to improving the health and health care of all Americans.

Notes

1. Foster, L. G. *Robert Wood Johnson: The Gentleman Rebel*. State College, Pa.: Lillian Press, 1999.
2. Ibid.
3. Ibid.
4. Diehl, D. "The Emergency Medical Services Program." *To Improve Health and Health Care 2000: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 2000.
5. Isaacs, S., and Knickman, J. (eds.) *Generalist Medicine and the U.S. Health System*. San Francisco: Jossey-Bass, 2004.
6. Keenan, T. "Support of Nurse Practitioners and Physician Assistants." *To Improve Health and Health Care 1998–1999: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 1999.
7. Showstack, J., Anderson Rothman, A., Leviton, L. C., and Sandy, L. G. "The Robert Wood Johnson Clinical Scholars Program." *To Improve Health and Health Care, Vol. VII: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 2004; Gardner, J., Krevans, J., and Mahoney, M. "A Conversation About the Clinical Scholars Program." *Medical Care*, 2002, 40(Suppl. II), 25–31.
8. For an examination of the Foundation's National Program structure, see Chapter Eight in this volume.
9. Price, D. "Foundations: A Time for Review." *New York Times*, September 9, 1984.
10. Chapter Eight in this volume.
11. For an examination of the program, see Diehl, D. "The Emergency Medical Services Program." *To Improve Health and Health Care 2000: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 2000.
12. For an examination of the Foundation's commitment to New Brunswick and New Jersey, see Dickson, P. "Tending Our Backyard: The Robert Wood Johnson Foundation's Grantmaking in New Jersey." *To Improve Health and Health Care, Vol. V: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 2002.
13. For an examination of the Foundation's grantmaking in research and evaluation, see Knickman, J. "Research as a Foundation Strategy." *To Improve Health and Health Care 2000: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 2000.
14. The principle has evolved recently to one stating, "The Foundation strives to speak with its grantees."
15. Karel, F. "Getting the Word Out: A Foundation Memoir and Personal Journey." *To Improve Health and Health Care 2001: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 2001.