I. ESSAY

Charting A New Course: A Conversation With Leighton E. Cluff
by John K. Iglehart

Q: Almost six years ago, I interviewed David Rogers, your predecessor as president of The Robert Wood Johnson Foundation (Health Affairs, Fall 1983). At that point, the foundation's assets totaled $1.4 billion, and its annual giving totaled about $50 million. What are the foundation's total assets today, and how much does it award in health-related grants every year?
A: The foundation's assets currently exceed $2 billion, and annual giving is around $100 million. Foundations are required by law to make grants that are the equivalent of 5 percent of their assets. If indeed our assets continue to grow as they have in the past, annual giving could reach $200 million within a decade.

Access To Primary Care

Q: You were affiliated with The Robert Wood Johnson Foundation for more than a decade before your elevation to the presidency in 1986. What do you regard as the foundation's single most impressive achievement in its seventeen-year history?
A: I think the foundation's most important contribution nationally has been to legitimize the issue of access to primary care. That was accomplished in a variety of ways. One was the support of service demonstration programs—programs that encouraged the development of innovative approaches to delivering general medical care through community hospitals, through teaching hospitals, and through health clinics in rural areas and inner cities. These efforts provided care directly to people who lacked access to it.

Second, the foundation promoted primary care through the support of selected medical training programs for physicians in internal medicine,

Leighton (Lee) Cluff became president of The Robert Wood Johnson Foundation in 1986. A physician and researcher, Cluff taught at The Johns Hopkins University School of Medicine and the University of Florida College of Medicine before joining the Johnson staff.
pediatrics, and family practice, and for nursing school faculty members, nurse practitioners, and physician assistants. Increasing access was also our primary goal in supporting more than $62.5 million in programs to help minority students in medical careers. We believed—and the data support that belief—that these students ultimately would tend to serve poor and minority people having access problems.

Third, the foundation legitimized primary care through its support for programs of health policy that studied access to care and its financing and for research that helped identify populations in need.

Q: Recently, The Robert Wood Johnson Foundation identified a new set of priorities. I want to discuss the reasons for these important programmatic shifts with you, but for the moment I am curious about why Johnson has diminished primary care as a priority in its new order. Has its goal of emphasizing primary medical care for the general population been achieved?

A: There are several reasons why we have reordered priorities. One is that three surveys of access to care in the past several years have indicated significant improvement on that front, for the general population and even within minority populations. Second, The Robert Wood Johnson Foundation’s board and staff recognized that the residual problems of access are confined pretty much to some specific groups and to people with certain health problems—acquired immunodeficiency syndrome (AIDS), chronic mental illness, dementia, and the like. We have refocused our concerns about access on these vulnerable populations and specific health problems.

Over the foundation’s first twelve years, it committed about $750 million to the improvement of general primary care. Now, we have not diminished primary care as a priority as much as recognized that a range of other compelling issues also need attention.

Q: Your background is that of a medical educator. Given the wealth of experience you have had in teaching the next generation of physicians, what is your level of anxiety over the growing imbalance of new doctors emerging from medical residency programs who are trained as subspecialists rather than primary care physicians?

A: The foundation now is exploring rather intensely the whole issue of medical education. One reflection of our commitment to this area is our continued support of the Robert Wood Johnson Clinical Scholars Program. One of its primary purposes is to help prepare young physicians who have completed their clinical training to deal effectively with some of the larger health care problems facing society. Currently, the foundation is exploring what further contribution it can make to the restructuring of medical education in the United States. Indeed, we believe the problem you mention must be addressed: that is, the growing discontinu-
ity between the training of new physicians and the interest of medical schools, on the one hand, and society's health care needs on the other. Another example of the discontinuity between people's health care needs and our health care institutions' ability to meet them is the critical nursing problem hospitals now face. We—along with The Pew Charitable Trusts—have launched a major effort to encourage hospitals to restructure their nursing services, with the ultimate goal being the improvement of care for hospitalized patients.

New Directions In Grant Making

Q: The Robert Wood Johnson Foundation announced in April 1988 that it would embark on some new program directions, specifically addressing (1) vulnerable populations such as children, the elderly, and the disabled; (2) specific diseases of regional or national concern, such as AIDS; and (3) problems of major national policy significance. What triggered this reassessment of the foundation's priorities?

A: A variety of factors come into play. As I have indicated, the foundation had already invested a whale of a lot of money on behalf of its strong belief in general primary care. Second, we have had a change in membership of the foundation's board of trustees. Board members and staff—myself included—believed that we had done enough in the field of general primary care and that other problems beckoned. So we took it upon ourselves in 1986 to explore problem areas in need of greater attention. In the course of that process, which took the entire year of 1987, we identified the revised priorities that you cited.

Q: I was fascinated by the foundation's decision to set a new course, particularly guided by a mandate from its board to "be bold and courageous—and fast." But I was left at sea trying to figure out what the new priority areas actually will be. It seemed to be that the rubrics are so broad that you could identify almost any of society's health care ills as falling within them. As you replace primary care as a priority, what do you believe will be the overriding emphasis or emphases of the foundation in the next few years?

A: The goals were purposely broad so that we need not return to the board every time we identify a new challenge. The watchwords, "Be bold and courageous—and fast," mean just that. The "fast" means that, as a foundation, we must be prepared to move into an area of need quickly, and we fully intend to do that. The "bold and courageous" is a recognition that some of the areas of need are very tough, complex problems—AIDS, substance abuse, teenage pregnancy, adolescent health, violence, and destructive behavior. Some of these problems transcend medical care. To address them, we must be prepared to take greater risks. By
contrast, primary care problems were in relatively familiar territory — in some ways, easier terrain for us.

Q: Let me ask you to elaborate on the newly identified priorities from the following viewpoint. Your “Dear Colleague” letter introducing the foundation’s new directions is almost a year old now. During this period, you have presumably begun to receive many more grant applications in areas other than the ones you had specified prior to that announcement. Obviously, there will be a substantial period of transition. No organization the size of Johnson transforms itself overnight. But as these grant applications have begun to arrive and the Johnson staff has continued to give thought to its new priorities, what grant-making areas are receiving priority attention?

A: There are several new areas that the foundation staff is currently exploring with the board of trustees that will, I am sure, begin to emerge over the next year or so. One way we can act faster and support a wide range of ideas in a new area is to do what we did in 1988 with AIDS: we issued a call for proposals, in which communities told us their ideas for approaching the problem, instead of our designing a model project format—a Procrustean bed, if you will—to which all applicants must conform.

Q: It sounds as though Johnson is gravitating toward more than one approach to grant making. Rather than simply setting down what the foundation will invest in, the foundation also seems to be more open to receiving innovative proposals that do not necessarily fall within tightly prescribed guidelines set out by the foundation. Am I right in that regard?

A: Yes, we are striving to open up the channels of grant making. In fact, we want to increase the submission of unsolicited proposals in areas of the foundation’s expressed interest, rather than having grant applicants only responding to prescriptive national programs drawn up by the foundation’s staff. For example, in early 1989, we will be distributing a call for proposals to examine the impact of the changes that have occurred over the past two decades in the financing and organization of health care delivery in this country. We are interested in knowing how these changes have affected the access to and quality and equity of health care services. Organizations will have a lot of latitude in how they respond to this call.

Other areas of interest are the serious health problems of our country’s Native American and Alaskan Native populations. We have communicated with hundreds of Native American and Alaskan Native groups indicating this interest and asking for proposals. Another area is our support for innovative service models for people with chronic mental illnesses. Under that topic we’re supporting a diverse group of projects nationwide. Over time, we may publicize an interest in other areas—the problems of destructive behavior and the challenges of medical ethics,
for example—in the same way. When I speak of medical ethics, I don’t mean just the death and dying issues and the plight of the newborn, low-birthweight infant, but also questions of equity: How does this country grapple with the national social issue of thirty-seven million Americans who do not have health insurance? How does this country face the issue of the black male with heart disease who is far less likely to undergo coronary bypass surgery than a white male with precisely the same disease? How do we face the fact that Washington, D.C., our nation’s capital, has the highest infant mortality rate of any city in the United States? I am not saying that we will work in all of these areas, but these problems do raise compelling questions for a civilized society.

Q: That represents a marked departure from past foundation policy, does it not?
A: Yes, it does. It reflects a view of the board and the staff that a foundation like ours simply does not have all the answers, that we cannot prescribe to the hundreds of diverse communities in the United States one single, preferred approach to very complex problems. As we embark on new directions, we are declaring explicitly that we do not have all the answers.

But there is a second point, equally important. As I have traveled this country over the past few years, it has become very clear to me that there are countless organizations representing community groups, church congregations, YMCAs, even academic health centers—and I mean “even”—that have developed enormously important and innovative approaches to dealing with some of their communities’ health problems. But most of these organizations have never submitted a proposal to the foundation. I have asked why, and the usual response has been, “We didn’t think that Johnson supported any activities other than its national prescriptive programs.” The only way we can change that image is to pronounce clearly our interest in receiving unsolicited proposals, and we are doing just that.

Q: How will these new directions affect the foundation’s staff and its traditional style of operation?
A: It will change the foundation’s internal style of operation significantly. Since April 1988, when the foundation disseminated my letter to thousands of interested parties, we have received a fivefold increase in the number of inquiries for support. Logistically, we don’t have the staff to deal with that increased workload, at least not yet. We plan to add some staff, and we plan to add a wing to our existing facility. But our strategy will be increasingly dependent upon using external experts and advisory groups to assist us in evaluating proposals in a given area. The structure will become somewhat comparable to the review system employed by the National Institutes of Health.
Aggressive Assault On AIDS

Q: The Robert Wood Johnson Foundation has provided two-thirds of the $65 million or so that private philanthropy has awarded on behalf of the struggle against AIDS. What triggered your foundation's early and rather aggressive assault on this disease while most other private philanthropies hung back, and what have you learned through the several grant cycles that Johnson has now been through in relation to AIDS?

A: I am delighted to respond to those questions, because I don't think the story has ever been adequately told. One afternoon in 1983, a senior program officer at the foundation, Paul Jellinek, came into my office and said, "Lee, the AIDS epidemic in this country is not going to go away. We have to pay more attention to it."

Well, as an infectious disease specialist, I was aware of the disease, although it had not been widely recognized at that time as a major public health problem. I encouraged Paul to seek the advice and counsel of Drew Altman, who was then a Johnson vice-president and is now Commissioner of Human Services for the State of New Jersey. The two of them working together gathered all of the information that they could, talked to consultants, and made site visits.

A leading question at the time was, how do you move a foundation into a programmatic area like AIDS, which other foundations had shied away from and which the federal government was neglecting? A key factor in the foundation's willingness to move was our new board chairman, Robert H. Myers. The chairman called the board together, the facts were set out and discussed, and the board concluded that AIDS was a problem that deserved the foundation's serious attention, even though it went counter to past policy not to work on specific diseases. In 1985, the board approved a four-year, $17 million AIDS program to develop the broad range of community-based services needed by people with AIDS. It was our first step. We've more recently funded fifty-four community-based AIDS prevention and services projects, bringing our total commitment to this area to nearly $46 million.

Q: I believe Johnson's single largest AIDS grant to date (nearly $4 million) was awarded to Boston's public television station, WGBH, for a series of programs to inform citizens in relation to the disease. What persuaded the foundation to make this rather unusual grant?

A: During the course of our AIDS grant making, we became concerned that many people were simply not well-informed about the disease, despite the many thirty-second public service spots on television, the mass mailing sent by the Surgeon General's office, and various other efforts to reach the public. At the time we were mulling this problem, WGBH approached us, asking whether or not the foundation would be
interested in helping to underwrite a public television program on AIDS. We grabbed at it. We thought we could reach a special audience—policymakers and community leaders—by disseminating information on AIDS through public television. These are the people who are making social policy decisions on AIDS-related issues. WGBH also will be distributing videotapes of the program and supplementary educational materials to some 5,000 high schools.

Informing The Public

Q: Are you of the view that the public pays a sufficient amount of attention to the world of private foundations and what they do?
A: No, I suppose that is the fault of the foundations themselves. As a group, foundations need to develop more effective mechanisms of informing the public about what we do and why we do it. It’s partly attributable, perhaps, to the strong belief in our culture that one should be modest about one’s “good works.” At The Robert Wood Johnson Foundation, we’ve always encouraged publicity about our grantees and their works, with less emphasis on the foundation as an institution. I do believe that Johnson is very well known in the health care community, because of our narrow grant-making focus. It surprises me that we are not better-known in the general population, since, all told, our service and training programs have touched the lives of so many people — perhaps one American in ten.

Q: What is your opinion regarding how well foundations evaluate their grant-making activities to determine whether they achieved their stated objective?
A: Here, too, I think foundations could improve their performance. We have several activities under way now that should provide a glimpse of Johnson’s record over the years. I am completing a book-length report on the activities of The Robert Wood Johnson Foundation from 1972 to 1989. The book covers our heritage, how the foundation got started, the purposes identified by the founder, and my views on how well we fulfilled his vision. The book also describes what we have learned and discusses what mistakes we made along the way. One thing we learned is that building new institutions through private grant making is risky unless the institution that one is building has the capacity to sustain itself once foundation funding is over.

We have developed a grants information system, which is an in-house mechanism that tracks the progress of every grant. We also have embarked on what we call retrospective analyses, in which an outside consultant examines an activity in which funding by the foundation had been ended for at least four years, and strives to determine whether the
program has continued, what were the lessons learned, and were our expectations correct about the need for the activity.

You raise an interesting point, though, and that is, how do we report this information to the public at large? That is a question that deserves some serious thought, but much of this information will be included in my forthcoming book.

Era Of Community Action

Q: Recently, Health Affairs published an interview with Alvin Tarlov, president of The Henry J. Kaiser Family Foundation. In the course of the interview, Tarlov suggested that other foundations also are moving their focus to the community level. As he put it, “It stems from a perception among foundations that social change can be effectively fashioned, customized, if you will, through local circumstances by community groups if those groups are empowered to assume responsibility for it. It’s a discovery. I don’t know where the discovery came from; perhaps California with its direct governance by public referendum has something to do with it. But in the United States there is an accelerating trend to empower local organizations and individuals in an effort to seek change. There is sort of a people’s democracy at work here.” Would you say that the new directions that Johnson plans to follow essentially square with Tarlov’s statement in this regard?

A: In part, yes. I agree with de Tocqueville’s revelation that community efforts to solve problems abound in this country. From that standpoint, what Tarlov was discussing is not new. I think that it is a basic reaffirmation of what de Tocqueville described as the essence of American democracy. I believe we are entering an era of greater emphasis on community action. This is going to be necessary in part because, in my view, it just isn’t going to be possible to meet all the services needs of a growing population of elderly people in this country by using paid professional help. We are reaching a limit. But this is a community problem for which community solutions are appropriate. Our Interfaith Volunteer Caregivers Program showed that one traditional community resource—religious congregations—can organize to provide a variety of home-based services for frail elderly and disabled people. In the twenty-five cities where we funded these projects, the interfaith coalitions recruited and trained volunteers, then carefully matched them with people in need.

Another reason we’ll see more community action, I think, is people’s disillusion with the idea that all of the problems of the United States can be addressed from Washington. This is a sufficiently diverse country that, in essence, what is right for Oshkosh is not necessarily right for...
Baton Rouge. Yet, the development of community solutions is an extraordinarily complex matter. For example, our Health Care for the Homeless Program drew in service providers of many kinds to try to weave a stronger fabric of community support for the homeless. We at Johnson could not tackle health care, and housing and education and employment all at the same time, and hoped that communities would add the other pieces. So we started with what we knew. In fact, my preferred approach is incremental action over a long period, initially on behalf of one problem. 

Q: Cite a specific example of how The Robert Wood Johnson Foundation will implement its new priorities.

A: Our recently announced substance abuse program reflects that approach. It’s a community-based program that seeks to mobilize broad community forces to deal with the issue of demand for illegal drugs and alcohol. We are realistic enough to recognize that it will take the better part of a decade to see any impact from this program. We also recognize that what works in one community will not necessarily work in another. Basically, one community may find that it can retard demand for illegal substances best by working through the public school system. Other communities may develop other interventions. We are open to considering any community’s approach if it has the potential for addressing its specific problem, but it must derive from a community’s own thinking and action.

Role Of Academic Health Centers

Q: You noted in your statement of new priorities that The Robert Wood Johnson Foundation would reduce its “traditional reliance upon a few major universities and medical centers for program direction and upon multisite national programs carried out under very close academic oversight for testing new approaches to health care delivery.” Given that statement, what is your opinion of universities and medical centers both as effective managers of large multisite national programs and also, generally speaking, as effective agents of change?

A: As you know, John, I spent much of my professional life in two major academic centers—twelve years at The Johns Hopkins University School of Medicine and a decade at the University of Florida College of Medicine. Besides my direct experience in those kinds of institutions, I am, moreover, an academic health center watcher, both in the private and public sectors. They are very effective in the provision of inpatient care to individuals. They are also extraordinarily effective in carrying out scientific research. But I have not been impressed with their ability to grapple with some of the critically important health problems of popula-
Q: Do academic health centers have a responsibility to grapple with these problems?
A: Absolutely. I find it disturbing personally to visit a medical school or an academic health center in an area where there are serious problems with substance abuse, suicide, sexually transmitted diseases, and services for the elderly, only to learn that the institutions are ignoring these problems. Medical schools pursue their interests in magnetic resonance imaging and computerized axial tomography scanning, in molecular biology, and in rare diseases, but they are not paying a hell of a lot of attention to the major problems of their own communities.

By contrast, other “nonmedical” institutions are. Take, for example, the many congregations that participated in our Interfaith Volunteer Caregiving Program serving the elderly and disabled. Grantees in other Johnson programs for the elderly—notably supportive services and dementia care—also are predominantly community-based agencies, not major medical centers. Yet these programs are addressing problems fundamental to the quality of life of elderly people and their families.

Q: In your experience, is there a difference between private and public institutions in terms of their active involvement in the community in which they reside?
A: In my view, the public institutions do take on a greater responsibility for the community where they reside. That, of course, reflects their historical mission. That doesn’t necessarily mean that they can always discharge this responsibility very well, but I think that they sense the shortcomings. The private school feels this community responsibility to a lesser extent. It is impressive, however, that there are some private medical schools that have been exceedingly effective in dealing with community health problems. For example, when Bob Ebert was dean of the Harvard Medical School, with assistance from the foundation he was instrumental in the development of the Harvard Community Health Plan. Even though the health plan subsequently became an independent entity, it influenced the interest of the medical school in grappling with the critical health problems of the community. Also, given the complexity of some of the major problems in community health today, the solutions are going to have to come from a broad spectrum of social institutions, working together.

Physicians may not—indeed, probably will not—be the major catalysts in these responses. Academic health centers are a terribly important source of innovative ideas, and goodness knows the foundation depends on them for a lot of things, and we will continue to do so. But they are not the sole possessors of the knowledge we need to tackle today’s problems, and so we, as Tarlov has stated, want to encourage community-based
proposals, too. That represents quite a divergence for The Robert Wood Johnson Foundation. If you look at a map that pinpoints where Johnson has invested its grants over the years, you will find significant clusters in Boston, Baltimore, New York City, New Haven, Connecticut, Durham, North Carolina, San Francisco, Los Angeles, and Seattle—all sites of major academic medical centers. In the future, we will be looking for new ideas from other sources, too.

A Life Of Public Service

Q: You have mentioned your affiliations with Johns Hopkins and the University of Florida. What are the other stations in your life, both individual and institutional, that have influenced your thinking along the way and guided you through life?

A: I was born and raised in Salt Lake City. My father was a lawyer, a graduate of the University of Chicago who returned to Salt Lake City to practice. He was probably as important in the formation of my own personal philosophy of life as any other person. He was a strong believer in public service. Unfortunately, he died quite young. He was not a Mormon, nor was my mother. But I grew up in a Mormon community, which, like most Mormon communities, was very socially minded. And that had a very formative influence on my life and why I was so interested in social issues rather than just being a physician who took care of individual patients. During the Great Depression Utah was one state in the union where no one was on public welfare. Basically, the church assumed the full responsibility for taking care of individuals in need. My grandmother, for example, who was widowed and poor, was cared for by the church. After my parents, the other important influence on my life has been Beth, the woman I married forty-four years ago. She was a teacher, and her mother was a professor at the University of Utah.

I went to medical school on the East Coast. This experience was shaped in part by a bout with tuberculosis, which I contracted as a sophomore. Because antibiotics were not yet available to counter the disease, I spent almost a year in a sanatorium in New York State. Two patients with whom I commiserated that year, also medical students, became professors of microbiology and biochemistry at Harvard and Duke. I learned a lot about being sick during that period, about being isolated from family and about facing a potentially lethal disease. I returned to medical school, finished my studies, and went on to an internship at Johns Hopkins. I fully intended to enter private practice after that stint, but became interested in biomedical research through the influence of the chief medical resident, Robert Austrian. Subsequently, I went to Duke for more training,
did a research stint at the Rockefeller Institute, and returned to Hopkins as chief resident. For more than a decade at Hopkins, I devoted considerable attention to the epidemiological study of hospital-acquired infection, and subsequently I started the nation's first intensive program to look at drug use and adverse drug reactions.

I left Hopkins because I recognized that the time had come when medical students could no longer be trained only within university hospitals. And I was also interested in pursuing some of the health problems that were increasingly besetting communities. Shortly after joining the faculty of the University of Florida, I developed in cooperation with Richard Reynolds a four-county health care services program, serving rather sizeable proportions of the population. As a consequence of my interest and involvement in this rural health care program and my pursuit of nontraditional ambulatory care training sites for medical residents, I was attracted to The Robert Wood Johnson Foundation twelve years ago.

To round out my family history, my wife and I have two daughters. One is an ordained Episcopalian priest and rector of her own church in New Brunswick, New Jersey. My other daughter is associate director of institutional relations at the University of North Carolina Medical Center. Previously, she worked for four years as a family and patient advisor and counselor in the Department of Pediatrics at the University of Florida Medical Center. She provided support services for children who were dying of cancer and their families.

Q: It sounds like the tradition of public service is alive and well in the Cluff family.
A: It certainly is.
Q: Thank you.