The Robert Wood Johnson Foundation Annual Report 1984

The Robert Wood Johnson Foundation

Annual Report 1984

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The Robert Wood Johnson Foundation is an independent philanthropy interested in improving health care in the United States. It was established in 1936 by General Robert Wood Johnson, who died in 1968.

Robert Wood Johnson devoted his life to public service and to building a family-owned business into a major international corporation. An astute businessman, a statesman, soldier, and patriot, General Johnson devoted much of his life to improving the world around him. He had a tenacity of spirit that enabled him to accomplish many of his goals, but he also planned for the long-range fulfillment of other objectives that could not be achieved in one man's lifetime.

Despite the intensity and determination he displayed in his role as a business leader, General Johnson had a warmth and compassion for those less privileged than he. He was always keenly aware of the need to help others, and during his lifetime, he helped many quietly and without fanfare.

The true measure of General Johnson's deep concern for the needs of others was his decision to leave virtually his entire estate to The Robert Wood Johnson Foundation. With the settlement of this bequest in December 1971, the Foundation began its transition from a local institution active primarily in New Brunswick, New Jersey, to a national philanthropy.

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The president's statement

The accelerating pace of change—trying to maintain perspective

In last year's Annual Report I suggested that a whole series of new developments were converging to create great pressures for change in our ways of delivering medical care to people in this country. Among them I listed rapid shifts in our ways of paying hospitals, a potential surplus of physicians, rapidly advancing technologies permitting much more care to be given outside the hospital, and a changing demography shown in the progressive aging of the United States. I further indicated that accelerating the process was a public sense of alarm and even anger about the dizzying escalation of medical care costs.

The passage of the year has made me realize my predictions, while on target, were too conservative. Our health care system is changing so fast, so fundamentally, and going in so many different and even contradictory directions, that health professionals and those who work with them are having a very hard time following it all. Interestingly, those who go to doctors as patients have not yet sensed the profound upheaval, but this realization will surely come soon.

It has been our Foundation's feeling since the outset, a feeling yet more intense today, that we could be most useful and effective, particularly in a climate of flux and uncertainty, if we focused our resources on only a few problems at a time. We have tried to select those that have loomed large in public importance, while trying to keep track of what changing health care arrangements mean for people's medical care. Thus, we have continued to work on the general agenda outlined over the last several years.

During 1984 we have put more emphasis in four areas that we believe to be of key public importance. They are:

- slowing the rate of increase in health care costs;
- improving the health and survival of newly born infants;
- improving the ability of the frail elderly to maintain function and independence; and
- improving access to medical care for those groups most seriously underserved within present health care arrangements.

As part of this latter theme, we have also attempted to "keep book" on which groups or segments of our society are having the most difficulties in obtaining necessary medical care during this period of rapid change. Let me describe what we have learned about each of these areas in more detail.

Slowing the nation's rising health care costs

For the first time in a number of years, 1983 saw a slowdown in the rate of rise of the nation's medical bill. Part of this was a result of the many recent cooperative expenditure reduction initiatives launched by business, government, labor, physicians, and hospitals. Much of it was also due to the overall reduction in inflation.

However, it is clear the nation still has a long way to go to bring health costs under control. From preliminary estimates, Americans spent $384.3 billion for health care in 1984, an 8.1 percent increase over what we spent in 1983.[1] Although this rise represents the lowest annual rate of increase seen during the last decade, health care costs have continued to rise more swiftly than the overall economy. In 1984, health care used up approximately $135.3 billion more dollars a year than it did in 1980 when our foundation, along with many other larger players on the scene, chose to focus attention on this problem.[2] In fact, the United States spent about $1,500 per person for health care in 1984 while Japan spent $500, Great Britain $400, France $800, and West Germany $900.[3]

Of yet more concern, the forecasts on future expenditures continue to look dreadful. As shown in Figure 1, independent projections suggest that despite present efforts, the nation's health spending will continue to increase at alarming rates, rising from $384.3 billion in 1984 to $690 billion in 1990, and to a staggering $1.9 trillion in the year 2000.

Figure 1

Forecasted health spending, 1984-2000 (preliminary estimates)

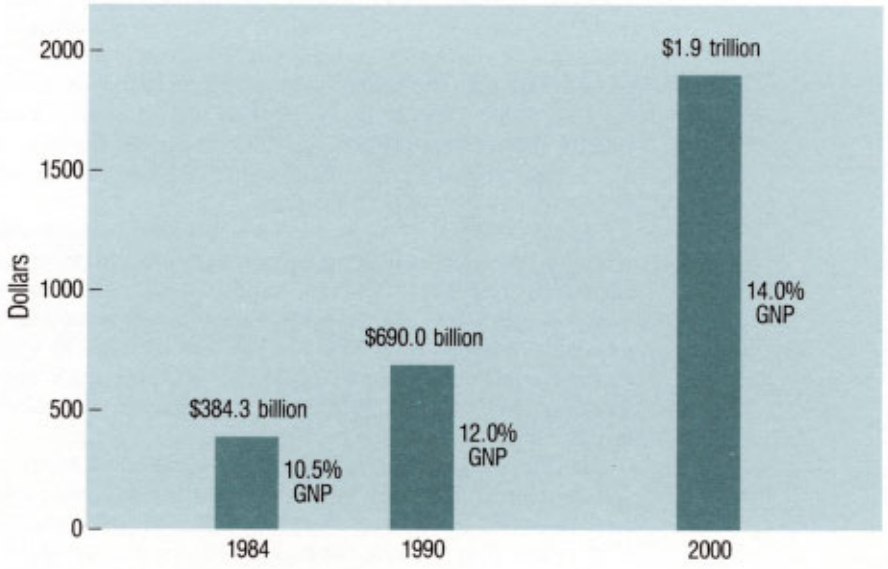
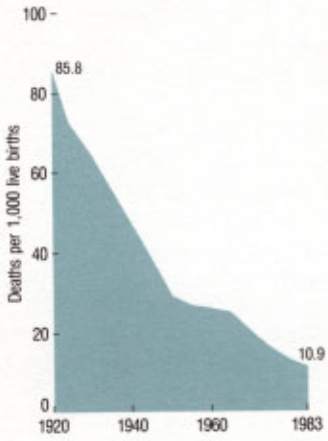


Figure 2
Infant mortality rates, 1920-1983



We simply cannot let this occur. Not only would such expenditures for health rob other important social programs, but they would threaten many of the recent gains made in securing improved medical care for some of the most vulnerable in our society. Further, such costs would tend to exacerbate a number of other broad national problems, as, for example, our worrisome federal deficit, the potential bankruptcy of Medicare, the increasing inability of many states to fully fund Medicaid, and the increasing lack of competitiveness of U.S. goods in world markets.

Since 1981, we have been supporting groups working on this problem through both competitive national programs and individual grants. Over $74 million, or roughly 36 percent, of our awards since that time have addressed the issue of costs. Major programs have been launched that are designed to reduce costs by cooperative community efforts or by prepaying for medical care. Physician-directed efforts at cost containment and programs to improve hospital payment mechanisms, to find better ways to finance long-term care, and to better manage patients with disabling chronic illnesses less expensively have also received Foundation support.

Because government, business, and many others have dramatically increased their efforts to reduce health care spending during this same period, we hope to increasingly focus our dollars on ideas and projects that fall outside the traditional scope of government or business support. But my central message is that progress has been made. It encourages me to believe that if enough public and private groups continue their work in this area, the nation's health care spending can be brought under better control without doing violence to the gains we have achieved during the last two decades.

Problems in the health and medical care of the very young and very old

This year we have placed more emphasis on programs directed at the health problems of the very young and very old. This stems from our conviction that much of our future national vitality depends on how effectively we as a people cope with the health and medical problems faced by those at each extreme of life's spectrum. Nearly one-half of all of the deaths in the United States each year occur in those under the age of one or over the age of 75.[4] Ignoring the problems of either of these two age-separated segments of our society puts at peril the other.

Let me give you a few facts on which I base that statement. First, our splendid successes in making entry into this world progressively less hazardous are well known. One hundred years ago infant mortality rates were 170 per 1,000. As shown in Figure 2, just since 1920, infant mortality rates have dropped from 85.8 per 1,000 to 10.9 in 1983, a level thought almost unobtainable only a decade ago. We have made enormous and satisfying progress in improving the life chances of children born in this country.

But this has had a secondary, quite logical effect which brings with it yet new problems. As infant mortality rates have dropped profoundly, so have birth rates and family size. And herein lies our dilemma. When this lowered birth rate is coupled with our equally dramatic successes in maintaining life

at the other end of the age spectrum, one sees emerging a future American population that grows steadily older during the coming decades. Thus, moving into the 21st century, our country will have a demography totally different from anything the world has ever known. It will have many more oldsters and proportionately many fewer young people.[5]

Let me punch home my point with a few statistics. In Roman times, the average life expectancy was about 25 years.[6] In 17th century Europe, it was 30.[7] In the United States, life expectancy was 49[8] in 1900, while today, it is almost 75 years.[9] We are certainly moving toward a very different world, one in which a progressively shrinking number of young people are going to be surrounded by an increasing number of old folk who have preceded them.

Few realize that since 1960 the elderly have fared better than children in terms of public expenditures. The reasons for this are many. They include, among others, the decrease in the number of children (down 7 percent between 1960 and 1982) and the sharp rise in those over 65 (up 54 percent between 1960 and 1980). It also stems from cutbacks in public programs for children while expanding those for older people, and the huge sums now spent on medical care during the last months of life for older citizens.[10]

These demographic changes need our close attention. For if we couple these facts together—a decreasing number of births, an increasing number of aged, and the knowledge that our sophisticated world of tomorrow will require the brightest and most able of young people to master and control it—the reasons for focusing on the very young and very old become obvious. It is absolutely critical to all of us that each child born alive in our society today and tomorrow have the maximum chances of being physically, mentally, and socially healthy. If our world is to function successfully in that future, our young people must become highly effective and productive citizens. Similarly, with more people attaining longer lives, our elderly must be helped to better maintain their independence and vitality than is the case today.

Improving the survival and health of newly born infants

Since the Foundation's arrival on the national scene, we have been concerned with the health of children. Our programs in this area have been many and varied, and have spanned the full age spectrum of young people. These broad efforts continue. Our present attention to newborn infants stems from the following: although many would argue that our record is unfairly measured against countries with smaller, more homogeneous populations, the fact remains that the United States continues to stand poorly on the world's infant mortality scorecard. This looms in importance when one realizes that deaths in infancy remain far and away the biggest contributor to childhood deaths in this country. Let me give you another statistic I find startling: of 100 children destined to die before the age of 20, 55 of them will die before they reach 1 year of age.[11]

What is the problem here? Again, we are victims of our own successes. Of these early deaths, three-fourths will occur in babies of low birthweight.

Thus, in part, because of the marked overall improvement in the life chances for babies, the problem of low birthweight has emerged as the single most important cause of death or subsequent handicaps in infancy. Although low birthweight babies (below 5.5 pounds) represent only 7 percent of all babies born, well over half of all infant deaths occur among this group.[12]

Low birthweight babies also have many more illnesses and are much more at hazard of having serious difficulties when of school age than their normal weight counterparts. The problem is even more serious for very tiny infants. The 1 percent of babies whose birthweights are very low—below 3.3 pounds—are 200 times more likely to die in the first few weeks of life, and 3 times more likely to suffer from congenital anomalies or developmental delay if they do survive.[13]

We have known these relationships for many years, but we have not yet been able to dramatically reduce the number of low birthweight babies who enter the world. Our medical advances to date have been in our abilities to keep tiny newborn babies alive. The development of regional systems of care for mothers and the management of tiny newborns in special neonatal intensive care units have done much to improve infant survival. But as shown in Figure 3, despite the dramatic overall changes in infant mortality, the incidence of low birthweight babies born in this country has declined only slightly in the past few years.

Figure 3

Infant mortality and low birthweight rates, 1970-1983

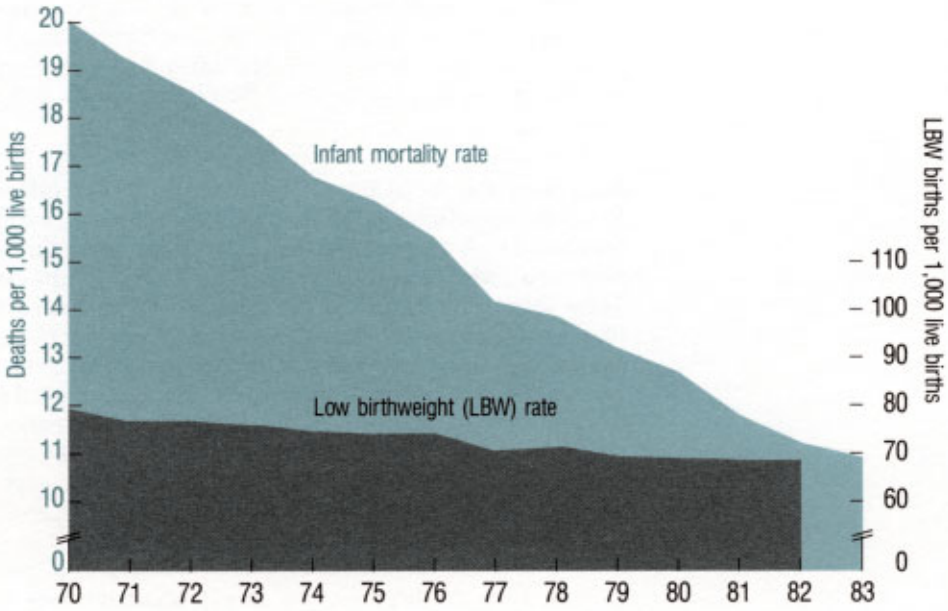
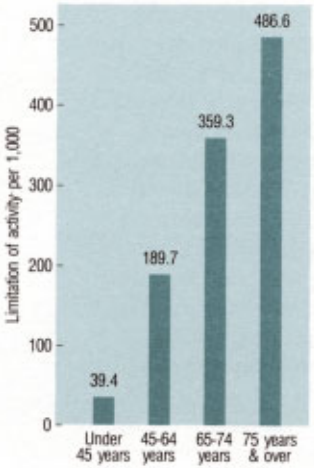


Figure 4

People with limitation of activity due to chronic condition by age, 1980



Today, there is a growing awareness that if we are to reach that goal that I mentioned — namely, that all surviving infants are healthy and capable of growing into responsible and productive adults — we must know more about the physiologic reasons for and develop better methods to reduce the number of infants born too small to function adequately.

For some years our foundation has invested heavily in the area of infant health. Since we began focusing on this issue, approximately $47 million of our grant funds have been aimed at improving infant survival and caring for low birthweight infants. We will continue to encourage improving access to state-of-the-art medical care for all children. However, during the next few years we will look with interest at programs designed to identify the conditions that increase the risk of having a low birthweight infant, programs seeking to reduce this risk, and research on new approaches to prevent premature labor and promote the normal growth and development of unborn infants.

Improving the quality of life for the elderly

And what is happening in the lives of the aged — the other end of life's spectrum? During the past 15 years, the United States has made dramatic improvements in life expectancy, and for most this has meant additional, fruitful years of life after retirement and opportunities to try new and different pursuits. Contrary to popular belief, most Americans over the age of 65 are not in poor health. According to recent statistics two out of three elderly Americans describe themselves as being in good or excellent health, and not seriously limited by major medical disabilities.[14]

But there is the other side of this coin. For about one out of five individuals over the age of 65, poor health is a major problem that commonly limits their ability to live independently.[15] It is chronic illness or disability, not death, that is now the nemesis of the old.

For most Americans, the chances of disability rise sharply after the age of 75. Almost one-half of the people over the age of 75, as shown in Figure 4, are limited in activities important to their daily living. As a result, many need assistance with personal care like bathing, or dressing, or eating, or using the toilet. The social significance of these facts lies in another fact: today, those 75 and over constitute the fastest growing segment of our society. Indeed, during the 1970s the number of elderly in the United States increased at a faster rate than the population of India![16] Those over 75 now number 11 million. By the year 2000, they are expected to number 17 million — with more than 100,000 Americans over the age of 100.[17]

But even today, the costs and burdens of the medical problems of old folk weigh disproportionately upon both the elderly and upon the rest of society. Nearly one-half of all patients in acute general hospitals, and over 70 percent of all patients in nursing homes, are over age 75. Unless we are able to improve our methods for medical management of the problems of our frail elderly to allow more of them to live independently, forecasts suggest that this country will move from 1 million people 75 years of age and older

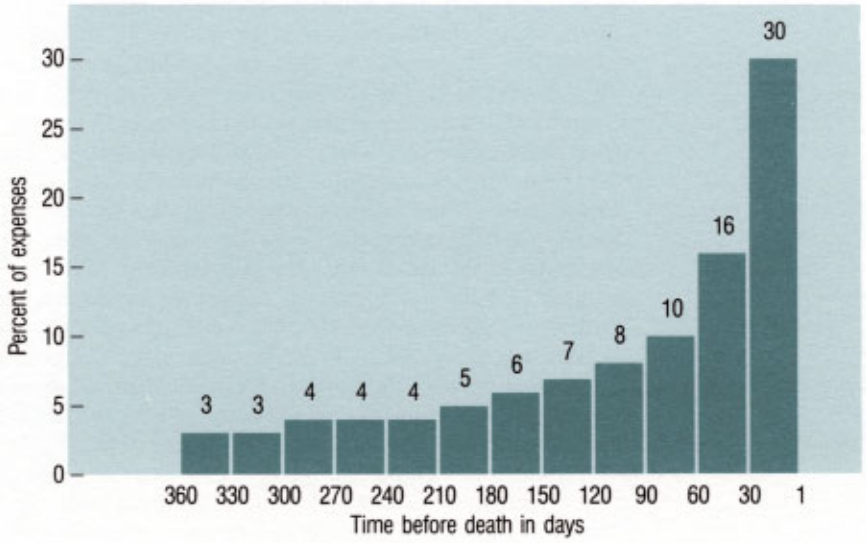
currently residing in nursing homes, to upwards of 5 million by the year 2040.[18] We should be able to do better than this.

Many are also concerned about two additional problems. One is the growing use of medical technologies to sustain life of an unacceptable quality for many of our elderly. The other is the quantity of medical resources expended upon them at the end of life (Figure 5). Alas, all too often it would appear that these expenses are incurred for highly invasive, sometimes painful, and sometimes perhaps inappropriate medical care efforts that elderly patients and their relatives might not sanction if they fully understood the situation. These problems also need more national attention and more imaginative, enlightened, and less costly solutions. For the first time in world history, old people are surviving in sufficient numbers to become not only a medical, but a social, economic, and political reality affecting the lives of all of us. How to make life better and more fulfilling for a growing, dependent, vulnerable, disabled, and aged population, especially for those over 75, has become one of our most important unsolved national dilemmas.

We have focused a substantial share of our resources on improving the lot of older people. Most of our funds have been targeted on programs seeking new ways to help fragile elderly patients remain *outside* hospitals or nursing homes and to improve the ability of these individuals to care for themselves. We have been impressed with how simple and how inexpensive some highly successful programs have been. We will continue work in this area.

Figure 5

Percent of Medicare expenses in the last year of life,1976



Continuing work on improving access to medical care for those most seriously underserved

Those who have followed our programs know that improving access to medical services for people having serious difficulties obtaining care has been a major focus of this foundation since it emerged on the national scene in 1972. Between 1972 and 1980, fully 76 percent of our funds were devoted to this purpose, including studies to pinpoint which groups or segments of our society were having the most difficulties in obtaining necessary medical care. Between 1981 and 1984, with the change in our program thrust, we have expended $74 million, or about 36 percent of our funding, in this traditional area of concern.

Since 1972, impressive strides have brought many previously underserved Americans into the medical care system. Increasing numbers of well-trained physicians, increasing coverage by private and public health insurance, and the availability of publicly-provided health services in many parts of the country have been responsible for a marked decline in the number of Americans unable to obtain appropriate medical care.

However, the rapid changes that are now occurring in the health care system — including changes in the ways hospitals are being reimbursed and the consequences of tough economic times — have led many to worry about whether those gains are being sustained. Thus, some of our recent grants have gone to groups trying to keep track of how well our system of medical care is serving us all. Other grants have supported institutions and groups targeting their efforts on improving access to medical care for those who remain underserved.

A study completed last year suggested that about 12 percent or 28 million Americans were continuing to have difficulty obtaining medical care.[19] This figure did not include the estimated 250,000 to 2-million-plus adults and children who are homeless and thereby uncounted in most major national studies. This study also showed that while being poor created problems in access, being without health insurance or losing it was an even more serious obstacle to obtaining care. As shown in Figure 6, those who were without health insurance were almost three times as likely to feel they were unable to obtain needed health services or that they had been denied health care for financial reasons. The same applied for children. As shown in Figure 7, while being poor or nonwhite increased a youngster's chance of not having a regular source of care, being uninsured had even more significance.

Knowing that lack of insurance makes one more likely to lose medical care sources and that the number of Americans without health insurance was growing has led us to try to determine what is happening to their medical care. Evidence is difficult to come by, but there are a few straws in the wind. For example: between 1980 and 1982 there was a 21 percent increase in the number of low-income Americans without health insurance. However, during this same period the nation's community hospitals, the traditional care institutions of last resort for low-income people, were only able to increase their provision of uncompensated medical care by less than

Figure 6

Indicators of barriers to access to health care,1982

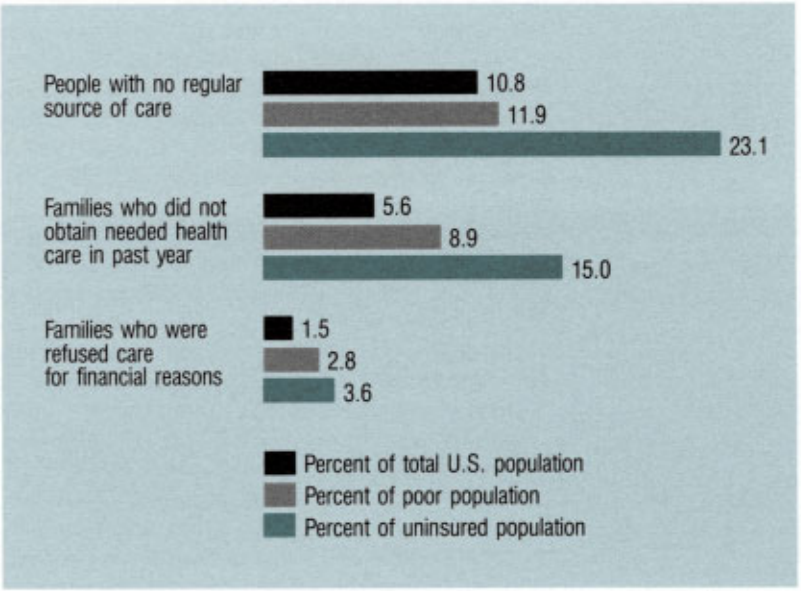


Figure 7

Characteristics of children under 17 who do not have a regular source of health care,1982

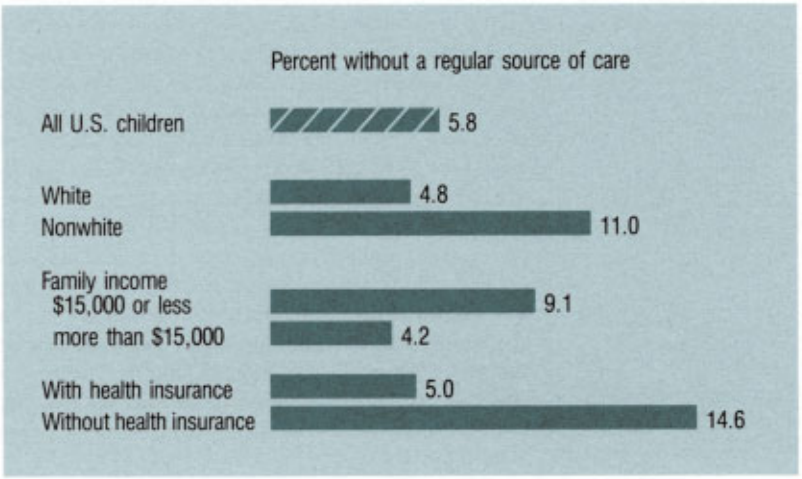
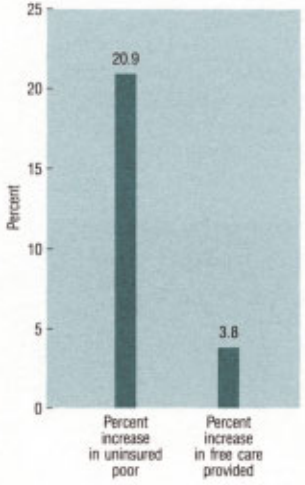


Figure 8

Percent increase in number of uninsured poor vs. free care provided by hospitals, 1980-1982



4 percent (Figure 8). This is by no means conclusive, but it does suggest that during this period more people may have had trouble getting care.

But clearly, the bottom line question is: "Does loss of medical care services actually make a difference in one's health?" Common sense says yes, but objective, quantifiable evidence is sparse. The few recent studies that have attempted to examine this problem, however, seem to come to the same conclusion. Statistics suggest that while infant mortality rates are going down in 55 of 81 cities for which such data are available, they appear to be rising in 23.[20] A California study that followed a Medicaid population with high blood pressure found that those who lost their Medicaid insurance and with it, continuing physician care, had a significant rise in blood pressure and more deaths than did a similar group who had not lost their medical care services.[21] Taken together, these preliminary reports are worrisome. The nation's medical coverage of vulnerable groups may be slipping.

Thus, the Foundation will continue to work on a variety of programs seeking to continue medical care services for all those who need them. The Foundation will look with interest at groups, or physicians, or hospitals, or institutions around the country that need assistance in developing or evaluating programs by which voluntary, state, or local governmental groups create new financing mechanisms to help pay for the care for those who now have difficulty getting it. We will also continue to assist those concerned with monitoring the success of such efforts.

Likewise, the Foundation will be looking beyond stopgap measures for imaginative ways to help health care institutions continuing to offer considerable care to the less fortunate. Institutional efforts to try to provide these services more effectively, or restructuring to help improve their financial viability while they maintain their services to the people without means, will receive attention. The Foundation, on a selective basis, will also continue its role of supporting studies to determine the extent and nature of the access to care problem.

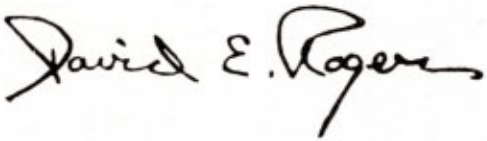
The growing challenge of transmedical problems

Since we began our work in health on the national scene in 1972, we have known that "health" or "medical" problems cannot always be neatly dissected away from a myriad of other problems—social, psychologic, or economic—that generally beset those in trouble.

Our work with many groups during the past several years has made us yet more vividly aware of this fact. Human misery is generally the result of, or accompanied by, a great untidy basketful of intertwined and interconnected circumstances and happenings. Often all need attention if the problem is to be overcome. We have found, however, that approaching a seemingly insoluble or multifaceted problem via the "health" route is often a way to start progress. Health care, and those who deliver it, are generally regarded as nonjudgmental and politically neutral. People will often open their doors and share their problems with a doctor or a nurse much more readily than with others in our society. In this way, the organization of medical care

services can serve as a magnet attracting other human support services so necessary for real programmatic success.

Thus, we will continue to approach tough, multifaceted problem areas of human concern via the "health" route. This is our area of expertise. However, in so doing, we will continue to look with favor on efforts of our grantees to link other support services to the delivery of medical care where such are needed for more satisfactory progress. In this way, we hope that many of our grantees will continue to be catalytic institutions for improvements in American life.



Text references

1. U.S. Department of Commerce International Trade Administration. *1985 U.S. Industrial Outlook: Prospects for Over 350 Manufacturing and Service Industries*. Washington, D.C.: U.S. Government Printing Office, January, 1985, p. 1.
2. Freeland, M. S., and C. E. Schendler. "Health Spending in the 1980s: Integration of Clinical Practice Patterns with Management." *Health Care Financing Review*, 5(3):1-89, Spring, 1984.
3. Macrae, Norman. "Health Care International: Better Care at One-Eighth the Cost?" *The Economist*, 291(7339):17-18, April 28, 1984.
4. U.S. National Center for Health Statistics. *Advance Report of Final Mortality Statistics, 1982. Monthly Vital Statistics Report*, 33(9 Supplement):10, December 20, 1984.
5. Rice, Dorothy P., and Jacob J. Feldman. "Living Longer in the United States: Demographic Changes and Health Needs of the Elderly." *Milbank Memorial Fund Quarterly/Health and Society*, 61(3):362-396, Summer, 1983.
6. Durand, John D. "Mortality Estimates from Roman Tombstone Inscriptions." *American Journal of Sociology*, 65:365, 1960.
7. Imhof, A. E. *The Years Won: On the Increase in our Lifespan Over the Past 300 Years or the Need for a New Attitude Toward Life and Death*. Munich: C. H. Beck, 1981.
8. U.S. National Center for Health Statistics. *Vital Statistics of the United States, 1980 Life Tables*, Vol. II, Section 6, May, 1984.

9. U.S. National Center for Health Statistics. *Advance Report of Final Mortality Statistics, 1982. Monthly Vital Statistics Report,* 33(9 Supplement):10, December 20, 1984.

10. Preston, Samuel H. "Children and the Elderly in the U.S." *Scientific American,* 251(6):44-49, December, 1984.

11. U.S. National Center for Health Statistics. *Advance Report of Final Mortality Statistics, 1982. Monthly Vital Statistics Report,* 33(9 Supplement):10, December 20, 1984.

12. McCormick, Marie C. "The Contribution of Low Birthweight to Infant Mortality and Childhood Morbidity." *New England Journal of Medicine,* 312(2):82-90, January 10, 1985.

13. *Ibid.*

14. U.S. National Center for Health Statistics. *Health, United States, 1983.* Washington, D.C.: U.S. Government Printing Office, 1983, p. 126.

15. Rice, Dorothy P., and Jacob J. Feldman. "Living Longer in the United States: Demographic Changes and Health Needs of the Elderly." *Milbank Memorial Fund Quarterly/Health and Society,* 61(3):362-396, Summer, 1983.

16. Preston, Samuel H. "Children and the Elderly in the U.S." *Scientific American,* 251(6):44-49, December, 1984.

17. U.S. Bureau of the Census. *Current Population Reports. Population Estimates and Projections. Projections of the Population of the United States by Age, Sex, and Race: 1983 to 2080. Current Population Reports,* Series P-25, No. 952, May, 1984.

18. Rice, Dorothy P., and Jacob J. Feldman. "Living Longer in the United States: Demographic Changes and Health Needs of the Elderly." *Milbank Memorial Fund Quarterly/Health and Society,* 61(3):362-396, Summer, 1983.

19. *Updated Report on Access to Health Care for the American People, Special Report,* No. One, Princeton, New Jersey: The Robert Wood Johnson Foundation, 1983.

20. United States Conference of Local Health Officers. *1980 Vital Statistics Summary* and *1982 Vital Statistics Summary.* Washington, D.C.

21. Lurie, Nicole, *et al.* "Termination from Medi-Cal — Does It Affect Health?" *New England Journal of Medicine,* 311(7):480-484, August 16, 1984.

Chart references

Figure 1.

Freeland, M. S., and C. E. Schendler. "Health Spending in the 1980s: Integration of Clinical Practice Patterns with Management." *Health Care Financing Review,* 5(3):1-68, Spring, 1984.

Tyson, K. W., and J. C. Merrill. "Health Care Institutions: Survival in a Changing Environment." *Journal of Medical Education,* 59(10):773-782, October, 1984.

U.S. Department of Commerce International Trade Administration. *1985 U.S. Industrial Outlook: Prospects for Over 350 Manufacturing and Service Industries*. Washington, D.C.: U.S. Government Printing Office, January, 1985.

Figure 2.

U.S. Bureau of the Census. *Statistical Abstract of the United States, 1984*. Washington, D.C.: U.S. Government Printing Office, 1983, p. 63.

U.S. National Center for Health Statistics. *Annual Summary of Births, Deaths, Marriages, and Divorces: United States, 1984. Monthly Vital Statistics Report*, 32(13):1, September 21, 1984.

Figure 3.

U.S. National Center for Health Statistics.

Health United States. 1976-1977. Washington, D.C.: U.S. Government Printing Office, 1977, p. 166.

Health United States. 1981. Washington, D.C.: U.S. Government Printing Office, 1981, p. 213.

Health United States. 1983. Washington, D.C.: U.S. Government Printing Office, 1983, pp. 100, 123.

Annual Summary of Births, Deaths, Marriages, and Divorces: United States, 1984. Monthly Vital Statistics Report, 32(13):1, September 21, 1984.

Advance Report of Final Natality Statistics, 1982. Monthly Vital Statistics Report, 33(6 Supplement):5, September 28, 1984.

Figure 4.

Rice, Dorothy P., and Jacob J. Feldman. "Living Longer in the United States: Demographic Changes and Health Needs of the Elderly." *Milbank Memorial Fund Quarterly/Health and Society*, 61(3):362-396, Summer, 1983.

Figure 5.

Lubitz, James, and Ronald Prihoda. "Use and Costs of Medicare Services in the Last Years of Life." *Health United States, 1983*. Washington, D.C.: U.S. Government Printing Office, 1983, p. 74.

Figure 6.

Updated Report on Access to Health Care for the American People, Special Report, No. One, Princeton, New Jersey: The Robert Wood Johnson Foundation, 1983.

Figure 7.

Unpublished data from a national survey of access to health care, conducted in mid-1982 by Louis Harris and Associates, Inc., for The Robert Wood Johnson Foundation. Additional analysis by the Center for Health Administration Studies, University of Chicago.

Figure 8.

Feder, Judith, *et al*. "Falling through the Cracks: Poverty, Insurance Coverage, and Hospital Care for the Poor, 1980 and 1982." *Milbank Memorial Fund Quarterly/Health and Society*, 62(4):544-566, Fall, 1984.

The 1984 grant program

The 1984 grant program

During 1984 the Foundation made 198 grants totaling $59.4 million in support of programs and projects to improve health care in the United States. The types of activity supported were:

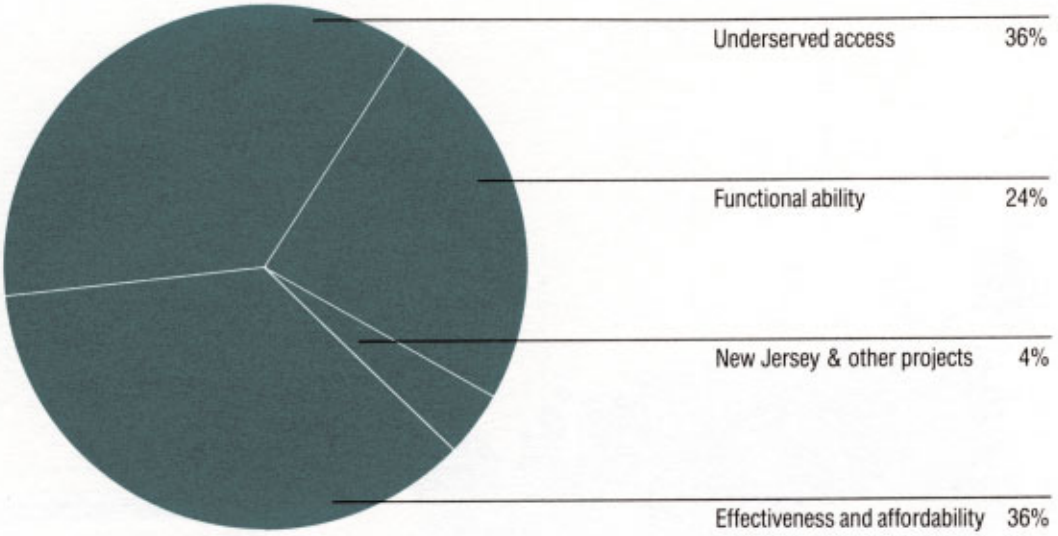
- developing and testing new ways of providing health care services, $42.6 million, or 72 percent of the 1984 grant funds;
- helping health professionals acquire new skills needed to make health care more accessible, affordable, and effective, $8.2 million, or 14 percent;
- conducting studies and evaluations to improve health care, $7.3 million, or 12 percent; and
- other projects, $1.3 million, or 2 percent.

These same grant funds, viewed in terms of the Foundation's principal objectives, were distributed as follows:

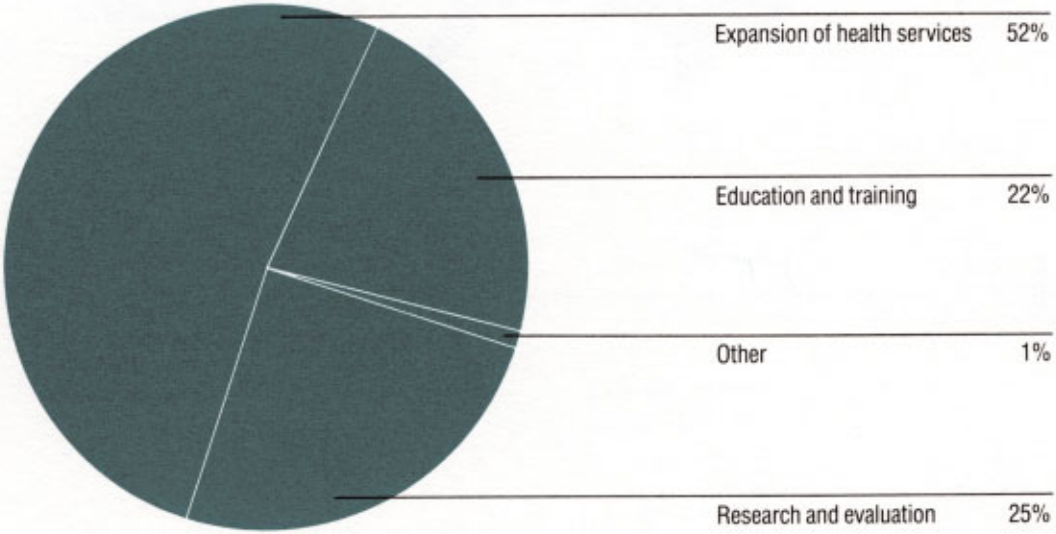
- $17.9 million, or 30 percent, for programs to improve access to personal health care for the most underserved population groups;
- $25.1 million, or 42 percent, for programs to make health care arrangements more effective and care more affordable;
- $13.5 million, or 23 percent, for programs to help people maintain or regain maximum attainable function in their everyday lives; and
- $2.9 million, or 5 percent, for a variety of other purposes, principally in the New Brunswick, New Jersey area where the Foundation originated.

Appropriations totaling $206.5 million have been made since 1981 when the Foundation changed its principal areas of interest to those stated above. The distribution of these funds by types of activities supported as well as by areas of interest is charted on the facing page. Since becoming a national philanthropy in 1972, our appropriations have totaled $584.9 million, and a chart depicting the geographic distribution of these funds is on page 26.

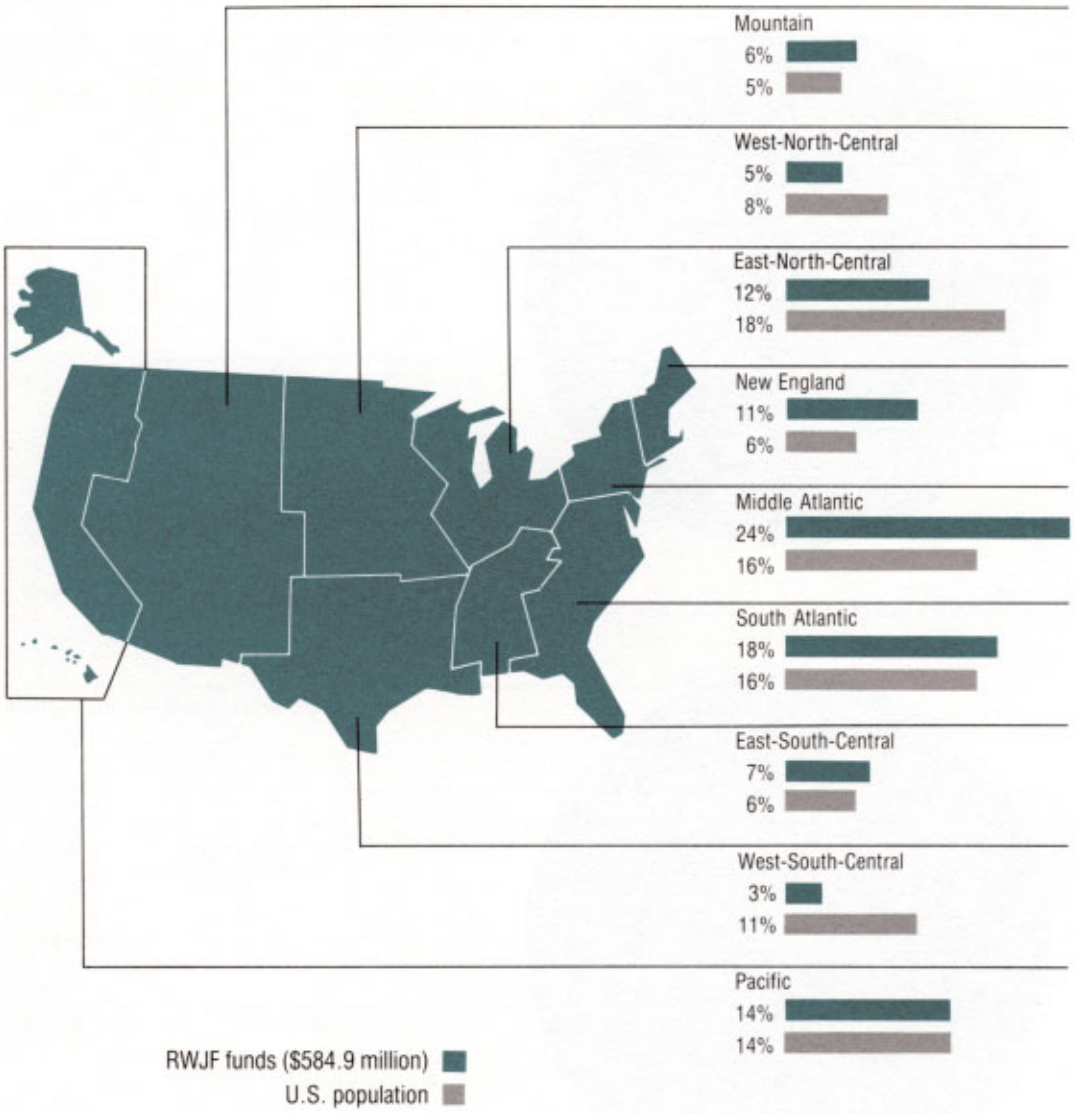
Appropriations by RWJF objectives and types of activities funded, 1981-1984



RWJF 4-year appropriations: $206.5 million



Appropriations by geographical region compared to population, 1972-1984



U.S. Population figures taken from the 1980 Census of Population, Supplementary Reports, U.S. Department of Commerce, Bureau of Census, May 1981.

MAJOR DEVELOPMENTS IN THE 1984 GRANT PROGRAM

The grant-supported projects and programs described in the first part of this section were selected to illustrate the Foundation's 1984 grant program. A complete list of grants made in this year begins on page 37.

In addition to the activities funded during 1984, staff of the Foundation continued to monitor and provide technical assistance to projects and programs supported by 493 grants authorized in previous years.

Also involved in this process were 18 senior program consultants and their staffs at medical schools, teaching hospitals, and other institutions providing technical assistance and direction for the Foundation's multi-grant national programs.

REDUCING COST INCREASES

Increasing health care costs, far exceeding the rates of inflation, continue to trouble this nation. While some cost-containment efforts have had limited success in slowing this increase, long-term answers remain elusive. One of the imperatives of this decade is to find solutions that can wrest us from this financial spiral without compromising access to, or the quality of, medical care. With Foundation support, a growing number of people and institutions across the country are committing to that effort.

Prepaid managed care

Thirteen health care organizations receiving grants under the Foundation's Program for Prepaid Managed Care are demonstrating one approach intended to contain medical costs while sustaining accessible and quality health care, particularly for the poor served under federal-state Medicaid programs. Primary care physicians in the participating institutions serve as gatekeepers for medical and hospital services for an enrolled group of at least 15,000 patients. The physicians or their institutions, working with state and federal agencies and private health insurers, are paid a fixed amount per person, regardless of the number or kinds of services that are provided. The Program is co-sponsored by the federal government's Health Care Financing Administration and the National Governors' Association.

Community programs

In the Foundation's Community Programs for Affordable Health Care, grants were made to groups in Worcester (Massachusetts), Pittsburgh, Detroit, and New York City to implement projects designed to slow the rate of increase in local health care costs. Up to eight more communities will ultimately receive implementation grants under this program. The projects are based on the combined efforts of representatives of hospitals, health insurers, business, labor, and other groups using a variety of cost-containment strategies. The Foundation's grants, of up to $1.5 million each, are matched with local funds equaling at least one-third of the total project costs. The Program is co-sponsored by the Blue Cross and Blue Shield Association and the American Hospital Association.

R & D on health costs

The Foundation also received and reviewed over 140 proposals under the Program for Research and Development on Health Care Costs. The Program annually offers three-year support for projects implementing or evaluating cost-saving strategies in the organization, financing, and delivery of health care. Grants in this the second round will be made in early 1985.

Strategies for hospitals

For several years, hospital costs have been increasing at rates two to three times the

Consumer Price Index. Inflation, accelerating health sector wages, and advancing technology are boosting the cost of services and compelling hospitals to take a new look at how to preserve their quality of care while restraining costs. One such program, at the New England Medical Center (NEMC), is decentralizing management so that the professionals prescribing and providing services, procedures, tests, and medications share in cost-accountability for their decisions. This is being done in each clinical department through a leadership team composed of a physician, nurse, and administrator that is responsible for determining protocols, staffing, and expenditures.

InterStudy is a Minneapolis-based research and consulting organization seeking to improve the delivery and financing of health services. One of its concepts, the Medical Staff-Hospital Joint Venture (MeSH), joins hospitals and private physicians together in cost-saving joint ventures for the delivery of health care. This may involve establishing HMOs or preferred provider organizations (PPOs), or negotiating with Medicare, Medicaid, private insurers, and private corporations for innovative packages of care. A grant this year is enabling InterStudy to help five hospitals set up projects using the MeSH arrangement.

One area frequently targeted for hospital cost reduction measures is that of ancillary

services — laboratory tests and radiological procedures. A grant to The University of Pennsylvania School of Medicine is supporting a study to identify the ancillary services that have increased the most, the cost implications of these services, and the varying patterns of their use by type of hospital and region of the country.

The National Executive Service Corps, with renewed grant support, is expanding its hospital management demonstration program. Under this program, retired senior executives from business are placed as consultants to assist hospitals in improving their management and governance.

Long-term care services

The growing numbers of elderly people in this country are increasing the need for long-term care services. The ACCESS project, under the auspices of the Monroe County Long Term Care Program in Rochester, New York, uses centralized, case-management for such community services. With this year's grant, however, researchers in the ACCESS project are continuing a randomized controlled study to evaluate whether this approach or neighborhood-based, decentralized case management — with limited caseload size and the substitution of informal unpaid services by family and friends — is more cost-effective in caring for the frail elderly.

Finally, with our support and additional funding from five other foundations, The Brookings Institution is conducting a national study to examine the options available for improving the financing and organization of long-term care for health-impaired elderly individuals. Guided by an advisory committee from the fields of health care, insurance, government, voluntary service, and public policy research, the study team will examine issues relating to current and future needs for long-term care services and the benefits of various strategies for improving the financing of services.

IMPROVING FUNCTIONAL STATUS

Medical care is sometimes seen as being limited to simply treating the biologic and physiologic problems created by disease. There is, however, another aspect to medical care: ensuring that people retain or resume maximal function allowing them to perform the ordinary tasks of daily living. This year in programs emphasizing this aspect of health care, we gave particular attention to infants threatened by disabling conditions because they were born too early or too small, and to those elderly individuals imperiled by, or at risk of developing, chronic health problems.

For infants

Approximately 240,000 low birthweight infants are born each year in this country. Because of their size — less than 2,500 grams or 5.5 pounds — they are at increased risk for developmental and neurological problems. This year, eight teaching hospitals and academic health centers received grants under the Infant Health and Development Program to participate in a three-year national collaborative study testing the efficacy of combining comprehensive pediatric care with developmental and educational services for the prevention of health and learning problems among low birthweight infants. The Program — the largest scientific study in this field to date — is directed from Stanford University with assistance in program development from the Frank Porter Graham Child Development Center in Chapel Hill, North Carolina.

The long-term health outcomes of high-risk infants — those infants who have survived major medical problems in the neonatal period — is under special study at The Children's Hospital of Philadelphia. The health and developmental status of these children will be assessed at preschool and early elementary schools ages. The study is also examining the impact that a child born at a low birthweight may have on a family over time, and is comparing the use of health, education, and

social services by very low birthweight children (less than 1,500 grams or 3.3 pounds) with those of normal birthweight.

Irrespective of birthweight, newborn infants that require treatment in neonatal intensive care units also appear to be at risk for neurodevelopmental difficulties. With previous support from the Foundation, the University of Iowa College of Medicine has established a statewide program for such children that involves assessments and medical referrals at ages 4, 9, 18, and 30 months. Our grant this year, with additional funding from the state of Iowa, the Iowa Crippled Children's Program, and three hospitals, is enabling the program to be extended to include a child's fifth year.

For elderly individuals

Twenty-five ecumenical coalitions of over 600 churches and synagogues in 17 states, the District of Columbia, and Guam—comprising such diverse groups as Christian, Jewish, Muslim, Bahai, and Buddhist congregations—have joined together and are reaching out to help isolated elderly and disabled people to continue living in their own homes. With grants announced this year, the Interfaith Volunteer Caregivers Program supports these coalitions in enlisting and training volunteers to locate those who need help and make sure that the mix of home health care, respite care, benefit programs, and other services essential to independent living are obtained. The Program is co-sponsored by the National Interfaith Coalition on Aging.

Ohio Presbyterian Homes, an interdenominational system of seven retirement communities, is using our funds to develop an outreach program. Incorporating the resources in the seven communities, and drawing upon a cadre of volunteers, the program has been designed to organize, coordinate, and provide in-home, long-term care services for frail elderly people living in nearby communities.

In the Foundation's Rural Hospital Program of Extended-Care Services, 26 rural hospitals are providing long-term care services using the "swing-bed" concept. This concept uses certain hospital beds for either acute or long-term patients depending upon needs. The Program is overcoming local shortages of nursing home beds and enabling rural residents to remain in their communities for long-term care. The University of Colorado Center for Health Services Research, with a grant approved this year, is joining with the federal Health Care Financing Administration to evaluate the effectiveness of the Foundation's program and to determine how well patients fare in hospital swing-beds as compared to traditional nursing homes.

Two other grants this year are helping to underwrite studies of innovative approaches to health care for elderly people. In one, a team of investigators at the University of Oregon's Center for Gerontology, in cooperation with the state's Senior Services Division, is studying the impact of a number of the state's legislative and administrative actions redesigning long-term care programs and identifying alternatives to nursing home care.

The other is a study of the Mountain States Health Corporation's geriatric nurse practitioner project. A persistent problem for elderly individuals in nursing homes has been the dearth of staff able to provide basic primary care, and hospitalization often occurs for even minor ailments. A $5-million, 11-state program, originally funded by the W.K. Kellogg Foundation, addressed this problem by placing the geriatric nurse practitioners in nursing homes to provide primary care. Our funds are being used by the Rand Corporation to examine the quality of care in this arrangement, together with its cost implications.

For young people

Teenage pregnancy continues to be an alarming problem. Today, well over a million U.S. teenagers become pregnant annually, and more than half of them bear children. With Foundation support, two programs are

focusing on this problem of children bearing children. A supplemental grant to The University of Pennsylvania School of Nursing is continuing a program geared to returning teenage mothers to school, helping them prevent subsequent pregnancies, and improving the health of their babies. In the other program, the National Research Council of the National Academy of Sciences, with additional funding from the Ford, Hewlett, and Rockefeller Foundations, is convening a panel of experts to conduct a comprehensive evaluation and report on a variety of public and private efforts to reduce teenage pregnancy and related health and social problems.

Between 1.2 and 3.8 million American children are chronically ill and unable to carry out even the most routine daily activities. For them, assistance is essential for bathing, dressing, eating, and other tasks most of us take for granted. To help these children and their families, The National Council on the Aging is collaborating with the Hospital for Sick Children and Children's Hospital National Medical Center in Washington, D.C., to develop, implement, and evaluate a model program enlisting senior citizens as volunteers trained to provide a variety of home services to chronically ill children and their families.

For others at risk

Staff at Memorial Sloan-Kettering Cancer Center and Brown University are continuing to evaluate an adult day hospital in which selected cancer patients receive their care as outpatients rather than inpatients. The study is assessing the physiologic, psychosocial, and cost implications of this new approach to cancer treatment.

Another grant—to Cornell University Medical College—is supporting the continuation of work to improve physicians' ability to make early determinations of the potential outcomes for patients with strokes. Investigators in the project are now able to classify patients according to their eventual capabilities to resume normal activities and return to work. This information is vital in selecting strategies of care most appropriate to the current and projected needs of individual stroke patients.

Exploring new approaches

This year, 197 requests for support were received and reviewed under the Foundation's Research and Development Program to Improve Patient Functional Status. Now in its fourth round, the Program provides support ranging from one to three years to approximately 20 projects demonstrating or evaluating interventions that prevent or alleviate disability and restore function. Grants will be made in early 1985.

ACCESS TO CARE

From the outset, one of the Foundation's primary objectives has been to improve access to health care for underserved groups in this country. This year we continued to target efforts on those who are among the most vulnerable.

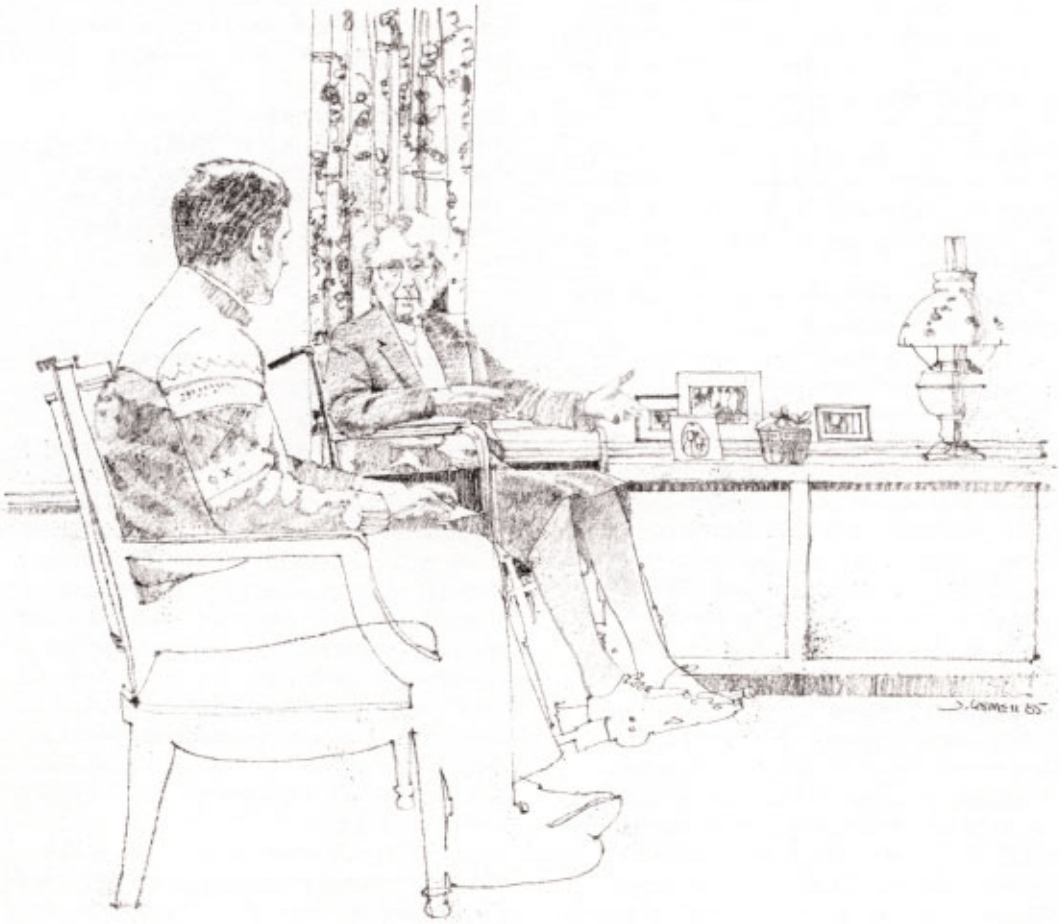
In our cities

Coalitions of public and private agencies in 18 of the country's largest cities received grants this year under the Health Care for the Homeless Program, which we co-funded with The Pew Memorial Trust. The people served under this program are a diverse population. They include alcohol and drug abusers, runaway children, deinstitutionalized mental patients, and individuals and even whole families that become homeless because of unemployment, lack of affordable housing, or family or life crises. Their health problems, often severe and potentially fatal, are rooted in the circumstances of their lives. For this reason, the Program is designed around a "transmedical" strategy addressing more than the immediate medical needs of the homeless. Grant funds are limited to health care activities, but the coalitions must also provide

for a full range of health, social, and other services, including food, shelter, and assistance for drug and alcohol problems. The Program is co-sponsored by the U.S. Conference of Mayors, with technical assistance and direction provided by St. Vincent's Hospital and Medical Center of New York.

In another project focusing on urban health issues, the U.S. Conference of Mayors' Research and Education Foundation and Georgetown University Center for Health Policy Studies are using our funds to implement a uniform system for tracking selected morbidity and mortality trends for the country's 25 largest metropolitan areas. This information system is intended to help public officials identify problems and make better informed decisions on health funding at local, state, and national levels.

The University of Chicago is using another of our grants to take a new look at how underserved groups in urban areas get their health care. In recent years, a major approach



to improving access to medical care has been to expand hospital outpatient clinics and neighborhood health centers, especially in inner cities where physicians have historically been in short supply. This latest study is examining whether the increasing numbers of physicians entering practice in recent years have reduced these shortages and changed how people in these communities receive care.

For people with chronic disorders

Providing dental care to developmentally disabled people has traditionally been impeded by the low fees paid by Medicaid, recent cutbacks in Medicaid coverage for dental services, and the limited number of states offering any dental coverage. In an attempt to develop a more cost-effective approach to meeting the dental needs of people who are developmentally disabled, the National Foundation for Dentistry for the Handicapped is using our funds to test a prepaid dental program as an alternative to Medicaid's fee-for-service arrangement for this target population.

Also with continued support this year, the New Jersey Hospital Association is implementing a statewide network of personal emergency response systems (PERS) electronically linking homebound people with a monitoring unit staffed around the clock, seven days a week. When an emergency occurs, a special device is used to signal the monitoring unit, which in turn notifies the nearest hospital participating in this system. It is anticipated that by the end of 1985 PERS will be available to the homebound in all of New Jersey's 21 counties.

For children in need

Continuation support to Harvard Medical School this year is assisting the Healthy Children project to encourage the development of model child care programs in communities where identifiable groups of children lack primary care and other health services. Pediatricians and others concerned with child health are encouraged to assess their communities' needs and then draw upon information materials and a network of experienced professionals available through the Harvard project in order to develop affordable, locally financed services.

Children with behavioral disorders or who have been labeled as chronic school failures often have subtle but debilitating neurodevelopmental problems not detected in the course of routine pediatric assessments. A grant to the University of Maryland School of Medicine is helping researchers test the Pediatric Early Elementary Examination (PEEX) with disadvantaged, inner-city children. PEEX is a sensitive neurodevelopmental assessment instrument which—if applicable to this population—can be used to assess a child's strengths as well as deficits. This is particularly crucial for children from low-income families—children who are often seen only in terms of their limitations. Children identified as having problems in the test will be referred to a cooperating school health program.

For others in need

Migrant workers and their families, poor and lacking health insurance and access to health services, typically go without care until a crisis occurs. Moreover, the hospitals, clinics, and physicians that do serve these families oftentimes bear a substantial financial burden in bad debts. The Center for Strategic Health Planning, an arm of the Central California Hospital Association, is using our grant to establish a prepaid, physician-managed health program for 5,000 migrant worker families. Payment is provided through the creation of a fund pooling whatever monies are available from government, the growers, and workers themselves, with Blue Cross of California underwriting and assuming full risk for the benefit package.

In 1981 the Arizona legislature authorized the state—then the only one in the nation not participating in Medicaid—to enter into an

agreement with the federal government to pay for health services for needy individuals. The new plan, called the Arizona Health Care Cost Containment System (AHCCCS), brought federal Medicaid funds to Arizona in the form of a three-year experiment using prepaid managed care networks to provide health care to indigent people. Prior to the inception of AHCCCS, the Foundation joined with the Flinn Foundation of Phoenix to sponsor a survey by Louis Harris and Associates on access to health care by the poor in Arizona. This year, a grant to Arizona State University's College of Business Administration is assisting a follow-up survey to evaluate the AHCCCS program.

The Associated Clinics of Appalachia (ACA) is using our funds for a prepaid program seeking to reduce Medicaid expenditures in rural West Virginia without restricting access to care for poor individuals. ACA is not providing services directly but rather contracting with the state and with clinics and private physicians to bring health care to patients under Medicaid.

Sustaining community services

Since May 1981, the Foundation's Community Care Funding Partners Program has been supporting centers tailored to bring front-line, affordable medical services to population groups identified as lacking adequate health care. In the Program, local foundations and corporations join with us in providing eight years of support for health services in underserved sections of their communities. This year two projects received assistance. The Cook Inlet Native Association in Alaska is establishing a primary care center for low-income elderly people. The other grant was awarded to the Flint (Michigan) Area Health Foundation, and is the second grant under the Program to this group. It is being matched locally to establish a health care center in the northwestern part of the city to serve an adolescent population at high risk for alcohol and drug abuse and teenage pregnancy. Thus far in the Community Care Funding Partners Program, nine projects in five communities have been assisted.

In recent years many primary care centers have been feeling the combined effects of increasing numbers of indigent patients and decreasing amounts of public assistance for their health care. The Foundation has responded by providing supplemental grants to centers established in underserved communities with Foundation support over the

last decade. The supplements are intended to give these centers additional time to gain more financial stability and compete for other public and private assistance. To qualify, each center must meet a set of specific criteria relating to present and future viability and the needs of the people they serve. In addition, they must receive a satisfactory on-site review by an independent management consulting firm. This year, four centers received grants under this program: two in Kentucky, one in Ohio, and one in the Bedford-Stuyvesant section of New York City.

PROFESSIONAL DEVELOPMENT

Eight Fellows were selected under the second round of the Minority Medical Faculty Development Program for support beginning in 1985. This program provides four-year postdoctoral research fellowships with outstanding biomedical mentors to young minority physicians committed to academic careers. The Program was designed to prepare faculty who can serve as role models for the succeeding generation of minority medical students and postdoctoral trainees.

Three other programs aimed at expanding opportunities for minority individuals in medicine were assisted this year. The Associated Medical Schools of New York, the National Fund for Medical Education, and Tulane Medical Center received grants to support educational and training programs.

The first five Fellows were selected under the Program for Faculty Fellowships in Health Care Finance. The purpose of the Program is to develop a cadre of university faculty with the specialized skills needed to teach and conduct research in the rapidly changing field of health care finance. Fellows undergo three months of study at The Johns Hopkins Medical Institutions followed by a nine-month placement in a public or private health care financing organization.

LOCAL GRANTS

Each year, selected projects are assisted in the New Brunswick, New Jersey area where the Foundation was established in 1936. This year a grant was made in support of the urban revitalization project spearheaded by New Brunswick Development Corporation, a coalition of community, business, and government leaders. Grants were also made to the United Way of Central Jersey and The Salvation Army.

FOR FURTHER INFORMATION

A brief, descriptive *Program Summary* is available without charge for each of our 1984 grants, as well as for those made in prior years. When possible, requests should include the title of the grant, the institutional recipient, and the grant ID number. This information on the 1984 grants is available from the listing beginning on the next page. Address requests to:

Communications Office
The Robert Wood Johnson Foundation
Post Office Box 2316
Princeton, New Jersey 08540

Summary of grants
authorized in the year ended December 31, 1984

		1984 grants authorized
American Association of Hospital Dentists Chicago, Illinois	*Establishing a national focus for hospital-based dentistry (for 4 years). ID#9246*	$ 350,000
American Red Cross—Essex Chapter East Orange, New Jersey	*Flood relief funds for residents of northern New Jersey (for 9 months). ID#9579*	100,000
Arizona State University, College of Business Administration Tempe, Arizona	*Study of access to medical care in Arizona (for 1 year). ID#9251*	159,195
Associated Clinics of Appalachia, Inc. Charleston, West Virginia	*Demonstration of prepaid managed health care in rural areas (for 26 months). ID#9018*	259,728
The Associated Medical Schools of New York New York, New York	*Program to increase minority enrollment in medicine (for 3 years). ID#8811*	567,199
Bedford Stuyvesant Family Health Center, Inc. Brooklyn, New York	*Program to strengthen the Center's capacity to provide health services (for 4 years). ID#9119*	432,262
The Brookings Institution Washington, D.C.	*Study of long-term care financing and organization (for 2 years). ID#9413*	250,000
University of California, Los Angeles, School of Dentistry Los Angeles, California	*Evaluation of the Hospital-Sponsored Ambulatory Dental Services Program (for 8 months). ID#9578*	46,618
The Center for the Study of Social Policy Washington, D.C.	*Study of long-range alternatives for providing care to the poor and disabled (for 2 years). ID#9097*	248,513
Center for Strategic Health Planning Modesto, California	*Farmworker health insurance project (for 2 years). ID#9467*	250,000
University of Chicago Chicago, Illinois	*Study of who uses OPDs, community clinics, and private practices (for 2 years). ID#9474*	215,401

		1984 grants authorized
Clinical Nurse Scholars Program	*Postdoctoral fellowships of advanced in-hospital clinical practice and research (for 1 year). ID#7514*	
University of California, San Francisco, School of Nursing San Francisco, California		$ 264,113
The University of Pennsylvania, School of Nursing Philadelphia, Pennsylvania		275,626
University of Rochester, School of Nursing Rochester, New York		266,959
Clinical Scholars Program	*Postdoctoral fellowships for young physicians to develop research skills in non-biological disciplines relevant to medical care (for 2 years). ID#5109*	
University of North Carolina at Chapel Hill, School of Medicine Chapel Hill, North Carolina		71,091
The University of Pennsylvania, School of Medicine Philadelphia, Pennsylvania		90,706
University of Colorado Center for Health Services Research Denver, Colorado	*Evaluation of the Rural Hospital Program of Extended-Care Services (for 34 months). ID#6741*	368,680
Community Care Funding Partners Program	*Primary care projects for underserved groups, jointly funded with local foundations and other private sources (for 5 years). ID#6397*	
Cook Inlet Native Association Anchorage, Alaska		257,832
Flint Area Health Foundation Flint, Michigan		350,668
Community Programs for Affordable Health Care	*Planning or implementation of local projects to slow the rate of health care cost increases (for the periods indicated). ID#6748*	
Allegheny Conference on Community Development Pittsburgh, Pennsylvania *(2 years)*		750,000
Arizona Community Foundation, Inc. Phoenix, Arizona *(1.5 years)*		100,000

		1984 grants authorized
Clark University, Graduate School of Management Worcester, Massachusetts *(2 years)*		$ 619,159
Greater Boston Forum for Health Action, Inc. Boston, Massachusetts *(1 year)*		100,000
Greater Detroit Area Health Council, Inc. Detroit, Michigan *(2 years)*		1,103,449
The Health Services Improvement Fund, Inc. New York, New York *(2 years)*		1,194,608
The Jane C. Stormont Hospital and Training School for Nurses Topeka, Kansas *(1.5 years)*		100,000
Tulsa Business Health Group, Inc. Tulsa, Oklahoma *(1.5 years)*		100,000
Conference of Mayors Research and Education Foundation Washington, D.C.	*Development of a uniform system to track health trends in cities (for 1 year). ID#9530*	188,022
Cornell University Medical College New York, New York	*Technical assistance and direction for the General Pediatrics Academic Development Program (for 1 year). ID#8760*	87,838
	Improving prognostic ability of physicians for patients with stroke (for 3 years). ID#9373	300,000
Dental Services Research Scholars Program	*Dental faculty fellowships in health services research (for 2 years). ID#6720*	
Beth Israel Medical Center New York, New York		98,150
University of California, Los Angeles, School of Dentistry Los Angeles, California		193,955
Columbia University, School of Dental and Oral Surgery New York, New York		101,000
Harvard University, School of Dental Medicine Boston, Massachusetts		120,044

		1984 grants authorized
University of Iowa, College of Dentistry Iowa City, Iowa		$ 96,000
Montefiore Medical Center Bronx, New York		100,000
Washington University, School of Dental Medicine St. Louis, Missouri		67,280
East Kentucky Health Services Center, Inc. Hindman, Kentucky	*Program to strengthen the Center's capacity to provide health services (for 4 years). ID#9120*	355,292
Educational Testing Service—Education Policy Research Institute Washington, D.C.	*Study of programs to increase medical school minority enrollment (for 16 months). ID#9123*	435,781
Emory University, The Carter Center Atlanta, Georgia	*Study of ways to further improve health in the United States (for 1 year). ID#9023*	250,000
Faculty Fellowships in Health Care Finance	*Program of study and field experience in health care finance for university faculty from related specialties (for 1 year). ID#8584*	
Boston University, School of Management Boston, Massachusetts		47,098
Columbia University, School of International and Public Affairs New York, New York		38,430
University of Illinois-Chicago, School of Urban Planning and Policy Chicago, Illinois		38,297
University of Oregon Development Fund Eugene, Oregon		40,452
Yale University, School of Medicine New Haven, Connecticut		45,920
Family Practice Faculty Fellowship Program	*Program to prepare physicians for academic careers in family practice (for the periods indicated). ID#3579*	
Case Western Reserve University, School of Medicine Cleveland, Ohio *(3.5 years)*		1,320,000

		1984 grants authorized
University of Missouri, Columbia, School of Medicine Columbia, Missouri *(3.5 years)*		$ 1,319,883
University of Washington, School of Medicine Seattle, Washington *(1 year)*		220,623
Frontier Nursing Service, Inc. Hyden, Kentucky	*Program to strengthen the capacity of the Service to provide health care (for 4 years). ID#9118*	325,464
Georgetown University, School of Medicine Washington, D.C.	*Analysis of health policy issues (for 1 year). ID#8893*	320,713
Glenville Health Association Cleveland, Ohio	*Strengthening a health center's capacity to provide essential medical services (for 4 years). ID#9105*	300,000
Grantmakers in Health New York, New York	*Educational program in health philanthropy (for 3 years). ID#9616*	150,000
Harvard University, Medical School Boston, Massachusetts	*Program to encourage the development of children's health services (for 2 years). ID#8763*	698,969
Health Care for the Homeless Program	*Projects involving urban coalitions of public and private agencies in providing and coordinating health and other services to the homeless (for 2 years). ID#8637*	
Boston City Hospital Boston, Massachusetts		650,499
University of California, Los Angeles, School of Nursing Los Angeles, California		681,720
Coalition for Community Health Care Milwaukee, Wisconsin		685,144
Colorado Coalition for the Homeless Denver, Colorado		597,343
Community Foundation of Greater Washington Washington, D.C.		749,905
Council of Community Services Nashville, Tennessee		615,488
Federation for Community Planning Cleveland, Ohio		700,000

		1984 grants authorized
Fremont Public Association Seattle, Washington		$ 754,422
Health and Welfare Council of Central Maryland, Inc. Baltimore, Maryland		577,232
City of Phoenix, Human Resources Department Phoenix, Arizona		669,392
St. Joseph's Hospital and Health Care Foundation Albuquerque, New Mexico		562,792
Travelers & Immigrants Aid of Chicago Chicago, Illinois		694,563
United Community Services of Metropolitan Detroit Detroit, Michigan		656,708
Health Policy Fellowships Program	*One-year fellowships with federal government in Washington, D.C., for faculty from academic health science centers (for 1 year). ID# 4888*	
Columbia University, School of Nursing New York, New York		48,542
University of Florida Gainesville, Florida		49,256
George Washington University, School of Medicine Washington, D.C.		47,040
Hahnemann University School of Medicine Philadelphia, Pennsylvania		45,363
The Ohio State University Research Foundation Columbus, Ohio		46,590
University of Washington, School of Public Health and Community Medicine Seattle, Washington		43,291
Human Dimensions in Medical Education La Jolla, California	*Training medical faculty in interpersonal skills (for 3 years). ID# 9442*	250,000
University of Illinois-Chicago, College of Nursing Chicago, Illinois	*Technical assistance and direction for the Clinical Nurse Scholars Program (for 1 year). ID# 8909*	170,611

	1984 grants authorized
Infant Health and Development Program	
National collaborative study to test the efficacy of combining early childhood development services with pediatric care in reducing the incidence of health and developmental problems among low birthweight infants (for 2 years). ID# 7891	
Albert Einstein College of Medicine of Yeshiva University New York, New York	$ 817,262
University of Arkansas, College of Medicine Little Rock, Arkansas	870,940
Children's Hospital Corporation Boston, Massachusetts	865,720
Medical Associates Research and Education Foundation (The Children's Hospital of Philadelphia — University of Pennsylvania) Philadelphia, Pennsylvania	876,310
University of Miami, School of Medicine Miami, Florida	827,215
The University of Texas, Southwestern Medical School at Dallas Dallas, Texas	852,158
University of Washington, School of Medicine Seattle, Washington	785,358
Yale University, School of Medicine New Haven, Connecticut	797,003
Interfaith Volunteer Caregivers Program	
Ecumenical coalitions of volunteers in projects coordinating health and other services enabling elderly and other vulnerable individuals to continue living in the community (for 3 years). ID# 7879	
Akron Area Association of Churches Akron, Ohio	150,000
Back Bay Aging Concerns Committee — Young and Old United, Inc. Boston, Massachusetts	150,000
Catholic Charities of the Diocese of Yakima Yakima, Washington	147,166
Catholic Community Services — Seattle/King County Seattle, Washington	150,000
Diocese of East Carolina — St. James' Episcopal Church Belhaven, North Carolina	150,000

	1984 grants authorized
The Downtown Cooperative Ministry, Inc. New Haven, Connecticut	$ 150,000
Eastern Oregon Community Development Council La Grande, Oregon	150,000
Eastern Virginia Medical Authority Norfolk, Virginia	150,000
First United Methodist Church Lewiston, Idaho	150,000
Good Shepherd Lutheran Church Albany, Oregon	149,754
Institute for Religion and Social Change Honolulu, Hawaii	149,995
Interfaith Conference of Metropolitan Washington Washington, D.C.	190,000
Interfaith Program for the Elderly, Inc. Milwaukee, Wisconsin	150,000
Interfaith Service Bureau Sacramento, California	149,551
Interfaith Volunteer Caregivers, Inc. Agana, Guam	150,000
Mahoning Valley Association of Churches Youngstown, Ohio	149,976
Metropolitan Inter-Faith Association Memphis, Tennessee	150,000
New Hampshire Catholic Charities, Inc. Manchester, New Hampshire	150,000
Pontiac Area Lighthouse, Inc. Pontiac, Michigan	147,737
San Antonio Urban Council, Inc. San Antonio, Texas	150,000
Service Center of Catholic Social Services Mobile, Alabama	150,000
Sisters of St. Joseph of Carondelet—Sisters of St. Joseph in California Oxnard, California	150,000
St. John's Baptist Church New York, New York	150,000

		1984 grants authorized
St. Stephen's Episcopal Church, Inc. Olean, New York		$ 150,000
Triniteam, Inc. Eau Claire, Wisconsin		149,853
InterStudy Excelsior, Minnesota	*Medical staff-hospital joint venture cost reduction program (for 2 years). ID#9695*	349,891
University of Iowa, College of Medicine Iowa City, Iowa	*Follow-up care for newborns treated in intensive care units (for 3 years). ID#9133*	146,280
Kingston Hospital Kingston, New York	*Technical assistance and direction for the Program for the Health-Impaired Elderly and the Interfaith Volunteer Caregivers Program and for other consulting services (for 1 year). ID#8759*	85,752
University of Maryland, School of Medicine Baltimore, Maryland	*Usefulness of pediatric early elementary exam among disadvantaged children (for 2 years). ID#9194*	211,522
Medic Alert Foundation International Turlock, California	*Development of a standardized personal emergency medical information system (for 2 years). ID#9379*	140,000
Medical Associates Research and Education Foundation (The Children's Hospital of Philadelphia—University of Pennsylvania) Philadelphia, Pennsylvania	*Study of long-term health outcomes of high-risk infants (for 4 years). ID#9104*	600,000
Meharry Medical College Nashville, Tennessee	*Technical assistance and direction for the Program to Consolidate Health Services for High-Risk Young People (for 1 year). ID#8758*	250,394
Memorial Sloan-Kettering Cancer Center New York, New York	*Evaluation of the efficacy of an adult day hospital for cancer patients (for 32 months). ID#9089*	463,815
Middlesex County College Edison, New Jersey	*Registered nurse refresher course (for 2 months). ID#8757*	11,768
Middlesex County College Foundation, Inc. Edison, New Jersey	*Health sciences scholarship program (for 10 months). ID#8122*	30,000
Middlesex General-University Hospital New Brunswick, New Jersey	*Property acquisition. ID#8939 and ID#9728*	1,315,444

		1984 grants authorized
Minority Medical Faculty Development Program	*Four-year program to provide two-year, biomedical, postdoctoral research fellowships (for 2 years). ID# 7854*	
Emory University, School of Medicine Atlanta, Georgia		$ 120,000
Monroe County Long Term Care Program, Inc. Rochester, New York	*Evaluation of alternatives in the management of care for the elderly (for 1.5 years). ID# 9500*	405,988
Montefiore Medical Center Bronx, New York	*Technical assistance and direction for the Program for Hospital Initiatives in Long-Term Care (for 1 year). ID# 8895*	273,979
National Academy of Sciences—Institute of Medicine Washington, D.C.	*Technical assistance and direction for the Health Policy Fellowships Program (for 3 years). ID# 7582*	559,300
National Academy of Sciences—National Research Council Washington, D.C.	*Study on adolescent pregnancy and childbearing (for 21 months). ID# 9243*	200,000
National Bureau of Economic Research, Inc. Cambridge, Massachusetts	*Studies on improving health and health care (for 3 years). ID# 9448*	188,734
The National Council on the Aging, Inc. Washington, D.C.	*Pilot volunteer project to assist chronically ill children and their families (for 1.5 years). ID# 8790*	185,637
National Executive Service Corps New York, New York	*Development of a senior executive program to aid hospitals (for 1 year). ID# 9594*	99,600
National Foundation for Dentistry for the Handicapped Denver, Colorado	*A prepaid dental program for the developmentally disabled (for 2 years). ID# 8918*	271,281
National Fund for Medical Education Hartford, Connecticut	*Support for summer programs for minority premedical students (for 1 year). ID# 8121*	100,000
New Brunswick Development Corporation New Brunswick, New Jersey	*Redevelopment program for New Brunswick, New Jersey (for 2 years). ID# 9280*	1,000,000
New England Medical Center Hospitals Boston, Massachusetts	*Decentralizing the management of a teaching hospital (for 2 years). ID# 9395*	410,000

		1984 grants authorized
New Jersey Hospital Association Princeton, New Jersey	*Implementation of a statewide network of personal emergency response systems (for 3 years). ID#9004*	$ 525,803
	Implementation of personal emergency response systems in two counties (for 10 months). ID#9345	114,850
New York University New York, New York	*Technical assistance and direction for the Rural Hospital Program of Extended-Care Services (for 1 year). ID#8897*	247,583
University of North Carolina at Chapel Hill Chapel Hill, North Carolina	*Development/Technical assistance for Infant Health and Development Program (for 1 year). ID#9367*	426,345
University of North Carolina at Chapel Hill, Health Services Research Center Chapel Hill, North Carolina	*Evaluation of the need for rural health center practice subsidies (for 1 year). ID#9147*	64,514
	Technical assistance and direction for the Dental Services Research Scholars Program (for 1 year). ID#8908	189,958
Ohio Presbyterian Homes Columbus, Ohio	*Strengthening the delivery of services to the frail elderly (for 2 years). ID#8773*	179,287
University of Oregon Development Fund Eugene, Oregon	*Study of program reforms in long-term care in Oregon (for 23 months). ID#9135*	123,689
Pace University, Graduate School of Nursing Pleasantville, New York	*Planning a university-wide health service managed by the nursing faculty (for 6 months). ID#9376*	53,899
The University of Pennsylvania, School of Medicine Philadelphia, Pennsylvania	*Study of variation in ancillary services utilization (for 2 years). ID#8931*	286,775
The University of Pennsylvania, School of Nursing Philadelphia, Pennsylvania	*Technical assistance and direction for the Teaching Nursing Home Program (for 1 year). ID#8904*	199,079
	Program to improve health outcomes for teenage mothers and their infants (for 4 months). ID#9663	30,000

	1984 grants authorized
Program for Prepaid Managed Health Care	
Collaboration of medical institutions with state and federal government and private insurers in projects offering health care by combining patient care management by primary care physicians with a capitated payment arrangement (for the periods indicated). ID# 7862	
Case Western Reserve University, School of Medicine Cleveland, Ohio (25 months)	$ 1,200,000
Chesapeake Health Plan, Inc. Baltimore, Maryland *(2 years)*	623,700
Children's Health Systems, Inc. San Diego, California *(2 years)*	1,016,070
City of Cincinnati, Board of Health Cincinnati, Ohio *(2 years)*	955,900
The Johns Hopkins Hospital Baltimore, Maryland *(2 years)*	934,495
Lutheran Medical Center Brooklyn, New York *(2 years)*	1,059,569
The Medical College of Pennsylvania Philadelphia, Pennsylvania *(2 years)*	862,988
Mile Square Health Center, Inc. Chicago, Illinois *(2 years)*	881,334
Public Health Trust of Dade County, Florida Miami, Florida *(2 years)*	741,835
University of Utah, College of Medicine Salt Lake City, Utah *(2 years)*	855,252
Watts Health Foundation, Inc. Los Angeles, California *(2 years)*	995,304

		1984 grants authorized
West Alabama Health Services, Inc. Eutaw, Alabama *(2 years)*		$ 695,860
University of Wisconsin Medical School Madison, Wisconsin *(2 years)*		68,720
Rand Corporation Santa Monica, California	*Effect of geriatric nurse practitioners on improving nursing home care (for 3 years). ID#9106*	477,002
St. Peter's Medical Center, School of Nursing New Brunswick, New Jersey	*Support for a nurse training program (for 10 months). ID#8896*	30,000
St. Vincent's Hospital and Medical Center of New York New York, New York	*Technical assistance and direction for the Health Care for the Homeless Program (for 1 year). ID#8906*	291,379
The Salvation Army New Brunswick, New Jersey	*Program of assistance to the indigent (for 1 year). ID#8892*	53,500
University of South Florida, College of Medicine Tampa, Florida	*Technical assistance and direction for the Rural Infant Care Program (for 1 year). ID#8898*	72,246
Stanford University, School of Medicine Stanford, California	*Technical assistance for and evaluation of the Infant Health and Development Program (for 1 year). ID#9013*	448,032
Tulane Medical Center New Orleans, Louisiana	*Program to increase minority enrollment in medical schools (for 2 years). ID#7295*	150,000
United Way of Central Jersey, Inc. Milltown, New Jersey	*Support of 1984 campaign (for 1 year). ID#9129*	275,000
PRESIDENT'S GRANTS		
The Academy for State and Local Government Washington, D.C.	*Exploration of options for health care for the medically indigent (for 5 months). ID#9755*	22,874
American Public Health Association, Inc. Washington, D.C.	*Implications of National Preventive Dentistry Program on public health dentistry (for 6 months). ID#9747*	5,319
Association of American Indian Physicians Oklahoma City, Oklahoma	*Feasibility study for evaluation of a model diabetes program (for 6 months). ID#9552*	35,881

		1984 grants authorized
University of California, Los Angeles, School of Medicine Los Angeles, California	*Cost containment study in treating acute ischemic heart disease (for 1 year). ID#9095*	$ 46,405
Children's Hospital National Medical Center Washington, D.C.	*Feasibility study of pediatric home care (for 9 months). ID#9514*	49,991
Concerned Citizens for Chronic Psychiatric Adults Middletown, New Jersey	*Establishment of a group home with Rutgers Community Mental Health Center (for 1.5 years). ID#8916*	15,000
Educational Testing Service—Education Policy Research Institute Washington, D.C.	*Study of programs to increase minority enrollment in medical education (for 2 months). ID#9333*	21,000
Hospital Research and Educational Trust Chicago, Illinois	*Update and expansion of inventory of U.S. health care data bases (for 10 months). ID#8654*	24,320
Illinois Department of Public Health Springfield, Illinois	*Pre-evaluation study of a teen parent program (for 5 months). ID#9190*	40,000
Jersey Shore Medical Center—Fitkin Hospital Neptune, New Jersey	*Feasibility of a hospital-based health program for the elderly (for 9 months). ID#9136*	25,000
The Johns Hopkins Hospital Baltimore, Maryland	*Final meeting of the Municipal Health Services Program principals (for 2 months). ID#9705*	16,657
The Johns Hopkins University, School of Hygiene and Public Health Baltimore, Maryland	*Providing access to evaluation data on the Regional Perinatal Program (for 14 months). ID#9382*	41,625
State of Maine, Department of Human Services Augusta, Maine	*National training workshop to foster replication of Maine child death study (for 4 months). ID#9698*	40,000
University of Massachusetts Amherst, Massachusetts	*Planning the evaluation of the Health Care for the Homeless Program (for 7 months). ID#9595*	36,532
	Analysis of medical records of New York clinics for homeless persons (for 5 months). ID#9730	49,194

		1984 grants authorized
University of Michigan, Health Administration Press Ann Arbor, Michigan	*Publication assistance for RWJF-supported research projects (for 1 year). ID#9504*	$ 10,000
Middlesex-Somerset-Mercer Regional Study Council Princeton, N.J.	*Central New Jersey transportation study project (for 10 months). ID#9501*	10,000
Mount Sinai School of Medicine of the City University of New York New York, New York	*Development of a communication device for impaired hospital patients (for 15 months). ID#9093*	40,971
National Academy of Sciences Washington, D.C.	*Independent appraisal of the Institute of Medicine (for 1 year). ID#9438*	20,000
National Academy of Sciences—Institute of Medicine Washington, D.C.	*Dissemination of a report on prevention of low birthweight (for 1 year). ID#9697*	19,751
The National Citizens' Coalition for Nursing Home Reform Washington, D.C.	*Study of nursing home quality of care (for 1 year). ID#9137*	49,570
National Conference of State Legislatures Denver, Colorado	*Health care cost containment project (for 1 year). ID#9263*	29,329
National Governors' Association Washington, D.C.	*Project to improve health care coverage for needy children (for 8 months). ID#9144*	49,669
National Public Radio, Inc. Washington, D.C.	*Series of programs on health care costs (for 1 year). ID#9241*	35,000
Northwestern University, J.L. Kellogg Graduate School of Management Evanston, Illinois	*Study of factors influencing hospital provision of ambulatory care (for 1 year). ID#9181*	50,000
New York University, Graduate School of Public Administration New York, New York	*Study of health services management initiatives (for 8 months). ID#10065*	17,102
Oregon Bioethics Conference, Inc. Portland, Oregon	*Program for community involvement in health care issues (for 6 months). ID#8989*	10,000

		1984 grants authorized
University of Pittsburgh, School of Dental Medicine Pittsburgh, Pennsylvania	*Study of dental radiography for health screening (for 1 year). ID#9555*	$ 25,117
Society of Teachers of Family Medicine Foundation Kansas City, Missouri	*Survey of alumni of faculty development programs to assess teaching needs (for 1.5 years). ID#9632*	6,000
Twin Cities Public Television, Inc. St. Paul, Minnesota	*Outreach activities associated with a child health television series (for 1 year). ID#9437*	20,000
University of Medicine and Dentistry of New Jersey Newark, New Jersey	*Planning program with New Brunswick's two hospitals (for 2 years). ID#9252*	11,500
Visiting Homemaker Home Health Aide Service of Middlesex County, Inc. North Brunswick, New Jersey	*Companionship program for the frail, homebound elderly (for 1 year). ID#9811*	10,000
Yale University New Haven, Connecticut	*Implications of changes in Canada's Medicare system for the United States (for 3 months). ID#9568*	11,322
Youth Employment Service of Princeton, Inc. Princeton, New Jersey	*Expansion of an intergenerational program (for 1 year). ID#9456*	4,300
	Total 1984 grants	$59,371,699
	Refunds of prior years' grants	(249,731)
	Cancellations of prior years' grants	(1,384,724)
	Transfer of grants	
	Balance returned by original grantees	(3,439,861)
	Transferred to new grantees	3,439,861
	Grants net for 1984	$57,737,244

Bibliography

Book chapters

Aday, Lu Ann. "Access to Medical Care in the United States: Equitable for Whom?" *National Health Policy: What Role for Government?* Edited by Isaac Ehrlich. Stanford, California: Hoover Institution Press, 1982.

Blake, Robert L., and M. Flynn. "Nutrition in Family Practice." *Textbook of Family Practice*. Third edition. Edited by Robert E. Rakel. Philadelphia: W. B. Saunders Company, 1984.

Branch, Laurence G., Linda J. Evans, and Pamela J. Perun. "Antecedents of Emotional Health Status Among the Elderly." *Aging and Technological Advances*. Edited by Pauline K. Robinson, Judy Livingston, and James E. Birren. New York: Plenum Publishing Corporation, 1985.

Brecher, Charles, *et al*. "Improving the Provision of Ambulatory Care by City Government: Preliminary Findings from the Municipal Health Program." *Ambulatory Care: Problems of Cost and Access*. Edited by Stuart H. Altman, Joanna Lion, and Judith LaVor Williams. Lexington, Massachusetts: Lexington Books, 1983.

Carter, William B. "Options to Shorten Time to CPR." *Sudden Cardiac Death in the Community*. Edited by Mickey S. Eisenberg, *et al*. New York: Praeger Publications, 1984.

Davis, Karen. "Cost Containment and Health Care in America." *Contemporary Issues in Health Care*. Edited by David J. Schnall and Carl L. Figliola. New York: Praeger Publications, 1984.

Greenberg, Jay N., and Walter N. Leutz. "The Social/Health Maintenance Organization and Its Role in Reforming the Long-Term Care System." *Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives*. Edited by Patrice Hirsch Feinstein, Marion Gornick, and Jay N. Greenberg. Baltimore: United States Health Care Financing Administration, 1984.

Klerman, L., and James F. Jekel. "Unwanted Pregnancy." *Perinatal Epidemiology*. Edited by Michael B. Bracken. New York: Oxford University Press, 1984.

McAnarney, Elizabeth R., and Donald E. Greydanus. "Gynecologic Procedures and Problems, Premarital Counseling, Contraception, Pregnancy and Abortion." *Current Pediatric Therapy Eleven*. Edited by Sydney S. Gellis and Benjamin M. Kagan. Philadelphia: W. B. Saunders Company, 1984.

Rimel, Rebecca W., and J. A. Jane. "The Management and Outcome of Patients with Minor Head Injury." *Neurosurgery*. Edited by R. H. Wilkens and S. S. Renzachary. New York: McGraw-Hill Book Company, 1984.

Walker, Deborah K. "Runaways." *Ambulatory Pediatrics III*. Edited by Morris Green and Robert J. Haggerty. Philadelphia: W. B. Saunders Company, 1984.

Journal articles

Aday, Lu Ann, *et al*. "Hospital-Sponsored Primary Care: II. Impact on Access." *American Journal of Public Health*, 74(8):792-798, August, 1984.

Aiken, Linda H., and Karl D. Bays. "The Medicare Debate — Round One." *New England Journal of Medicine*, 311(18):1196-1200, November 1, 1984.

Altman, Drew E., and Saul M. Kilstein. "Hospital Closures in Perspective." *Health Services Research*, 18(4):587-592, Winter, 1983.

Anderson, Gerard, and Earl P. Steinberg. "Hospital Readmissions in the Medicare Population." *New England Journal of Medicine*, 311(21):1349-1353, November 22, 1984.

Avorn, Jerry. "Benefit and Cost Analysis in Geriatric Care: Turning Age Discrimination into Health Policy." *New England Journal of Medicine*, 310(20):1294-1301, May 17, 1984.

Book chapters

Aday, Lu Ann. "Access to Medical Care in the United States: Equitable for Whom?" *National Health Policy: What Role for Government?* Edited by Isaac Ehrlich. Stanford, California: Hoover Institution Press, 1982.

Blake, Robert L., and M. Flynn. "Nutrition in Family Practice." *Textbook of Family Practice*. Third edition. Edited by Robert E. Rakel. Philadelphia: W. B. Saunders Company, 1984.

Branch, Laurence G., Linda J. Evans, and Pamela J. Perun. "Antecedents of Emotional Health Status Among the Elderly." *Aging and Technological Advances*. Edited by Pauline K. Robinson, Judy Livingston, and James E. Birren. New York: Plenum Publishing Corporation, 1985.

Brecher, Charles, *et al*. "Improving the Provision of Ambulatory Care by City Government: Preliminary Findings from the Municipal Health Program." *Ambulatory Care: Problems of Cost and Access*. Edited by Stuart H. Altman, Joanna Lion, and Judith LaVor Williams. Lexington, Massachusetts: Lexington Books, 1983.

Carter, William B. "Options to Shorten Time to CPR." *Sudden Cardiac Death in the Community*. Edited by Mickey S. Eisenberg, *et al*. New York: Praeger Publications, 1984.

Davis, Karen. "Cost Containment and Health Care in America." *Contemporary Issues in Health Care*. Edited by David J. Schnall and Carl L. Figliola. New York: Praeger Publications, 1984.

Greenberg, Jay N., and Walter N. Leutz. "The Social/Health Maintenance Organization and Its Role in Reforming the Long-Term Care System." *Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives*. Edited by Patrice Hirsch Feinstein, Marion Gornick, and Jay N. Greenberg. Baltimore: United States Health Care Financing Administration, 1984.

Klerman, L., and James F. Jekel. "Unwanted Pregnancy." *Perinatal Epidemiology*. Edited by Michael B. Bracken. New York: Oxford University Press, 1984.

McAnarney, Elizabeth R., and Donald E. Greydanus. "Gynecologic Procedures and Problems, Premarital Counseling, Contraception, Pregnancy and Abortion." *Current Pediatric Therapy Eleven*. Edited by Sydney S. Gellis and Benjamin M. Kagan. Philadelphia: W. B. Saunders Company, 1984.

Rimel, Rebecca W., and J. A. Jane. "The Management and Outcome of Patients with Minor Head Injury." *Neurosurgery*. Edited by R. H. Wilkens and S. S. Renzachary. New York: McGraw-Hill Book Company, 1984.

Walker, Deborah K. "Runaways." *Ambulatory Pediatrics III*. Edited by Morris Green and Robert J. Haggerty. Philadelphia: W. B. Saunders Company, 1984.

Journal articles

Aday, Lu Ann, *et al*. "Hospital-Sponsored Primary Care: II. Impact on Access." *American Journal of Public Health*, 74(8):792-798, August, 1984.

Aiken, Linda H., and Karl D. Bays. "The Medicare Debate — Round One." *New England Journal of Medicine*, 311(18):1196-1200, November 1, 1984.

Altman, Drew E., and Saul M. Kilstein. "Hospital Closures in Perspective." *Health Services Research*, 18(4):587-592, Winter, 1983.

Anderson, Gerard, and Earl P. Steinberg. "Hospital Readmissions in the Medicare Population." *New England Journal of Medicine*, 311(21):1349-1353, November 22, 1984.

Avorn, Jerry. "Benefit and Cost Analysis in Geriatric Care: Turning Age Discrimination into Health Policy." *New England Journal of Medicine*, 310(20):1294-1301, May 17, 1984.

Barry, Michele, *et al*. "Clinical Findings in Southeast Asian Refugees: Child Development and Public Health Concerns." *JAMA*, 249(23):3200-3203, June 17, 1983.

Bedell, Susanna E., Paul D. Cleary, and Thomas L. Delbanco. "The Kindly Stress of Hospitalization." *American Journal of Medicine*, 77(4):592-596, October, 1984.

Bedell, Susanna E., and Thomas L. Delbanco. "Choices about Cardiopulmonary Resuscitation in the Hospital: When Do Physicians Talk with Patients?" *New England Journal of Medicine*, 310(17):1089-1093, April 26, 1984.

Birnbaum, Howard G., and David Kidder. "What Does Hospice Cost?" *American Journal of Public Health*, 74(7):689-697, July, 1984.

Blendon, Robert J., and Drew E. Altman. "Public Attitudes About Health-Care Costs: A Lesson in National Schizophrenia." *New England Journal of Medicine*, 311(9):613-616, August 30, 1984.

Bohannan, Harry M., *et al*. "Indications for Sealant Use in a Community-based Preventive Dentistry Program." *Journal of Dental Education*, 48(2 Supplement):45-55, February, 1984.

Brett, Allan S. "Hidden Ethical Issues in Clinical Decision Analysis." *New England Journal of Medicine*, 305(19):1150-1152, November 5, 1981.

Brook, Robert H., *et al*. "Does Free Care Improve Adults' Health: Results from a Randomized Controlled Trial." *New England Journal of Medicine*, 309(23):1426-1434, December 8, 1983.

Cherkin, Daniel C., Roger A. Rosenblatt, and L. Gary Hart. "The Impact of Residency Training on the Productivity of Family Physicians." *Inquiry*, 21(2):152-160, Summer, 1984.

Cluff, Leighton E. "Economic Incentives of Faculty Practice: Are They Distorting the Medical School's Mission?" *JAMA*, 250(21):2931-2934, December 2, 1983.

Deguchi, Janet J., Thomas S. Inui, and Diane P. Martin. "Measuring Provider Productivity in Ambulatory Care." *Journal of Ambulatory Care Management*, 7(2):29-38, May, 1984.

Deyo, Richard A. "Pitfalls in Measuring the Health Status of Mexican Americans: Comparative Validity of the English and Spanish Sickness Impact Profile." *American Journal of Public Health*, 74(6):569-573, June, 1984.

Egdahl, Richard H. "Should We Shrink the Health Care System?" *Harvard Business Review*, 62(1):125-132, January-February, 1984.

Feder, Judith, Jack Hadley, and Ross Mullner. "Poor People and Poor Hospitals: Implications for Public Policy." *Journal of Health Politics, Policy and Law*, 9(2):237-250, Summer, 1984.

Fries, James F. "The Compression of Morbidity." *Milbank Memorial Fund Quarterly/ Health and Society*, 61(3):397-419, Summer, 1983.

Garber, Alan M., Victor R. Fuchs, and James F. Silverman. "Case Mix, Costs, and Outcomes: Differences between Faculty and Community Services in a University Hospital." *New England Journal of Medicine*, 310(19):1231-1237, May 10, 1984.

Ginzberg, Eli. "The Monetarization of Medical Care." *New England Journal of Medicine*, 310(18):1162-1165, May 3, 1984.

Hoekelman, Robert A., Michael Klein, and James E. Strain. "Who Should Provide Primary Health Care to Children: Pediatricians or Family Medicine Physicians?" *Pediatrics*, 74(4):460-477, October, 1984.

Hughes, Susan L., David S. Cordray, and V. Alan Spiker. "Evaluation of a Long-Term Home Care Program." *Medical Care*, 22(5):460-475, May, 1984.

Kruse, Jerry. "Long Term Reactions of Women to Electronic Fetal Monitoring During Labor." *Journal of Family Practice*, 18(4):543-548, April, 1984.

Lion, Joanna, *et al.* "Ambulatory Visit Groups: A Prospective Payment System for Outpatient Care." *Journal of Ambulatory Care Management,* (Special Issue: *Ambulatory Care Financing*), 7(4):30-45, November, 1984.

Logsdon, Donald N., and Matthew A. Rosen. "The Cost of Preventive Health Services in Primary Medical Care and Implications for Health Insurance Coverage." *Journal of Ambulatory Care Management,* 7(4):46-55, November, 1984.

Lohr, Kathleen N., William R. Lohr, and Robert H. Brook. "Understanding the Variations in the Use of Services: Are There Clinical Explanations?" *Health Affairs,* 3(2):139-148, Summer, 1984.

Lurie, Nicole, *et al.* "Termination from Medi-Cal—Does It Affect Health?" *New England Journal of Medicine,* 311(7):480-484, August 16, 1984.

McCormick, Marie C., Sam Shapiro, and Barbara Starfield. "High-Risk Young Mothers: Infant Mortality and Morbidity in Four Areas in the United States, 1973-1978." *American Journal of Public Health,* 74(1):18-23, January, 1984.

Mechanic, David. "The Transformation of Health Providers." *Health Affairs,* 3(1):65-72, Spring, 1984.

Miller, C. Arden. "The Health of Children, A Crisis of Ethics." *Pediatrics,* 73(4):550-558, April, 1984.

Newhouse, Joseph, *et al.* "Does the Geographical Distribution of Physicians Reflect Market Failure?" *Bell Journal of Economics,* 13(2):493-505, Autumn, 1982.

Pozen, Michael W., *et al.* "A Predictive Instrument to Improve Coronary-Care-Unit Admission Practices in Acute Ischemic Heart Disease: A Prospective MultiCenter Clinical Trial." *New England Journal of Medicine,* 310(20):1273-1278, May 17, 1984.

Proceedings of the Second Annual Conference: The Robert Wood Johnson Dental Services Research Scholars Program. Special issue of *Journal of Dental Education,* 48(11), November, 1984.

Reichgott, Michael J., and J. Sanford Schwartz. "Acceptance by Private Patients of Resident Involvement in Their Outpatient Care." *Journal of Medical Education,* 58(9):703-709, September, 1983.

Rogers, David E., and Robert J. Blendon. "The Academic Medical Center Today." *Annals of Internal Medicine,* 100(5):751-754, May, 1984.

Rose, Christopher C., Jane G. Murphy, and J. Sanford Schwartz. "Performance of an Index Predicting the Response of Patients with Acute Bronchial Asthma to Intensive Emergency Department Treatment." *New England Journal of Medicine,* 310(9):573-577, March 1, 1984.

Rubenstein, Lawrence Z., and Alan S. Robbins. "Falls in the Elderly: A Clinical Perspective." *Geriatrics,* 39(4):67+, April, 1984.

Schwartz, William B., and Henry J. Aaron. "Rationing Hospital Care: Lessons from Britain." *New England Journal of Medicine,* 310(1):52-56, January 5, 1984.

Siscovick, David S., *et al.* "The Incidence of Primary Cardiac Arrest During Vigorous Exercise." *New England Journal of Medicine,* 311(14):874-877, October 4, 1984.

Starfield, Barbara, *et al.* "Who Provides Health Care to Children and Adolescents in the United States?" *Pediatrics,* 74(6):991-997, December, 1984.

Strauss, Michael J. "The Political History of the Artificial Heart." *New England Journal of Medicine,* 310(5):332-336, February 2, 1984.

Strull, William M., Bernard Lo, and Gerald Charles. "Do Patients Want to Participate in Medical Decision-Making?" *JAMA,* 252(21):2990-2994, December 7, 1984.

Tyson, Karen W., and Jeffrey C. Merrill. "Health Care Institutions: Survival in a Changing Environment." *Journal of Medical Education*, 59(10):773-782, October, 1984.

Wells, Kenneth B., *et al*. "Do Physicians Preach What They Practice? A Study of Physicians' Health Habits and Counseling Practices." *JAMA*, 252(20):2846-2848, November 23/30, 1984.

Williams, Mark E., and Nortin M. Hadler. "The Illness as the Focus of Geriatric Medicine." *New England Journal of Medicine*, 308(22):1357-1360, June 2, 1983.

Reports

Bell, Robert M., *et al*. *Treatment Effects in the National Preventive Dentistry Demonstration Program*. Rand Report R-3072-RWJ. Santa Monica, California: Rand Corporation, 1984.

Curtis, Richard E. *Governors' Guide to Health Care Cost Containment Strategies*. Washington, D.C.: National Governors' Association, 1984.

Foch, Craig B., *et al*. *Cost of Treatment Procedures in the National Preventive Dentistry Demonstration Program*. Rand Report R-3034-RWJ. Santa Monica, California: Rand Corporation, 1984.

Minority Students in Medical Education: Facts and Figures. Washington, D.C.: Association of American Medical Colleges, Office of Minority Affairs, 1983.

National Study Group on State Medicaid Strategies. *Restructuring Medicaid: An Agenda for Change*. 3 vols. Washington, D.C.: Center for the Study of Social Policy, 1984.

Audiovisual materials

Going to the Doctor (10 minute videotape for children 5-15). San Francisco: University of California-San Francisco, Pediatric Communication Group, 1983.

Healthy Children (14 minute videotape). Produced for Harvard University, Division of Health Policy Research and Education on the development of health care programs for children in five communities. New York: Editel, 1984.

Joint Ventures Between Hospitals and Physicians for Ambulatory Care: Conflict or Cooperation (four 60 minute videotapes of a teleconference; recorded September 21, 1983). Chicago: American Hospital Association, 1984.

Financial statements

Introduction to financial statements

The annual financial statements for the Foundation for 1984 appear on pages 61 through 64. A listing of grants authorized in 1984 begins on page 37.

Grants authorized in 1984, net of cancellations and refunds of prior years' grants, totaled $57,737,244. Program development, evaluation, administrative and investment expenses for the year came to $6,499,754; and federal excise tax on income amounted to $1,504,229, making a grand total of expenditures of $65,741,227. This total was $9,839,822 less than gross investment income of $75,581,049. In 1983, total expenditures were $4,600,258 less than gross revenue.

A list of investment securities held at December 31, 1984 is available upon request to the Treasurer, The Robert Wood Johnson Foundation, Post Office Box 2316, Princeton, New Jersey 08540.

William R. Walsh, Jr.
Vice President and Treasurer

Opinion of independent certified public accountants

To the Trustees of
The Robert Wood Johnson Foundation:

We have examined the statement of assets, liabilities and foundation principal of The Robert Wood Johnson Foundation as of December 31, 1984 and 1983 and the related statement of investment income, expenses, grants and changes in foundation principal for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the financial statements referred to above present fairly the financial position of The Robert Wood Johnson Foundation at December 31, 1984 and 1983 and the investment income, expenses, grants and changes in foundation principal for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Coopers & Lybrand

Newark, New Jersey
January 18, 1985

The Robert Wood Johnson Foundation
Statement of assets,
liabilities and Foundation principal
at December 31, 1984 and 1983

	1984	1983
Assets		
Cash	$ 336,821	$ 301,151
Investments (at cost, or market value on dates of gifts) (Note 2):		
Johnson & Johnson common stock 19,000,000 shares in 1984, 19,383,258 shares in 1983 (quoted market value $686,375,000 and $792,290,670)	181,555,501	185,217,742
Fixed income investments (quoted market value $478,391,830 and $438,517,784)	471,839,399	441,726,659
Program related investments	2,550,000	1,600,000
Land, building, furniture and equipment at cost, net of depreciation (Note 1)	6,182,684	5,493,650
	$662,464,405	$634,339,202
Liabilities and Foundation principal		
Liabilities		
Unpaid grants (Note 1)	$106,413,521	$ 96,951,485
Federal excise tax payable	1,631,602	3,037,623
Total liabilities	108,045,123	99,989,108
Foundation principal	554,419,282	534,350,094
	$662,464,405	$634,339,202

See notes to financial statements.

The Robert Wood Johnson Foundation
Statement of investment income, expenses, grants and changes in Foundation principal
for the years ended December 31, 1984 and 1983

	1984	1983
Investment income:		
Dividends	$ 22,775,328	$ 21,807,002
Interest	52,805,721	44,429,201
	75,581,049	66,236,203
Less: Federal excise tax	1,504,229	1,319,217
Investment expenses	369,558	275,341
	73,707,262	64,641,645
Expenses:		
Program development and evaluation	4,492,739	3,743,785
General administration	1,637,457	1,439,083
	6,130,196	5,182,868
Income available for grants	67,577,066	59,458,777
Grants, net of refunds and cancellations	57,737,244	54,858,519
	9,839,822	4,600,258
Adjustments to Foundation principal:		
Capital gains on sale of securities less related federal excise tax (Note 3)	10,228,266	114,265,916
Contributions received	1,100	200
	10,229,366	114,266,116
Net increase in Foundation principal	20,069,188	118,866,374
Foundation principal, beginning of year	534,350,094	415,483,720
Foundation principal, end of year	$554,419,282	$534,350,094

See notes to financial statements.

1. Summary of Significant Accounting Policies:

   Grants are recorded as payable in the year the grant requests are authorized by the Board of Trustees. At December 31, 1984 unpaid grants are as follows:

Year Grant Authorized	Amount Unpaid at December 31, 1984
1980	$ 947,562
1981	7,421,610
1982	15,717,193
1983	30,406,929
1984	51,920,227
	$106,413,521

   Depreciation of $228,547 in 1984 and $201,498 in 1983 is calculated using the straight-line method over the estimated useful lives of the depreciable assets.

   Interest and dividend income is recorded when received and expenses are recorded, except for federal excise taxes, when paid. The difference between the cash and accrual basis for such amounts is considered to be immaterial.

2. The quoted market value of the sizeable investment in Johnson & Johnson common stock does not necessarily represent the realizable value of such investment.

3. The net capital gains on sales of securities for the years ended December 31, 1984 and 1983 were as follows:

	1984	1983
Johnson & Johnson common stock	$ 9,767,461	$109,652,193
Other securities, net	460,805	4,613,723
	$10,228,266	$114,265,916

4. Substantially all employees of the Foundation are covered by a retirement plan which provides for retirement benefits through the purchase of individually-owned annuities. The Foundation's policy is to fund costs accrued. Pension expenses were $343,304 and $289,859 in 1984 and 1983, respectively.

Secretary's report

The Foundation lost two valued trustees emeriti with the deaths of Judge Klemmer Kalteissen and John H. Hoagland in 1984. Each one gave generously of his time and energy, and we are indebted to both of them for their leadership and service to the Foundation.

At the December meeting of the board, Wayne J. Holman, Jr., was elected to the office of trustee emeritus of the Foundation, having served as trustee of the Foundation for over 21 years. Upon his election as trustee emeritus, Mr. Holman was cited by the board for his loyal and distinguished service to the Foundation.

Staff changes

At its July meeting the Board of Trustees elected Drew E. Altman, Ph.D., to the office of vice president. In January 1985 Annie Lea Shuster was promoted to senior program officer.

Jeffrey C. Merrill, M.P.H., joined the Foundation in July as assistant vice president. Mr. Merrill previously was the director of the Center for Health Policy Research Studies at Georgetown University and a senior program consultant to the Foundation for data research and analysis. He has a master's degree in public health from The Johns Hopkins University.

Rolando A. Thorne, M.P.H., joined the staff in March as program officer. Prior to joining the Foundation Mr. Thorne worked as the assistant to the director of Montefiore Medical Center in New York City. He received his master's degree in public health from Yale University.

Peter Goodwin, M.B.A., joined the Foundation in July as financial analyst. Before joining the Foundation Mr. Goodwin worked at Beth Israel Medical Center in New York City. He received a master's degree in business administration from Baruch College, City University of New York.

Carolyn H. Asbury, Ph.D., joined the staff in September as program officer. Dr. Asbury received her Ph.D. from the Wharton School, The University of Pennsylvania. Prior to coming to the Foundation she finished her work as a senior fellow at the Leonard Davis Institute of Health Economics, The University of Pennsylvania.

Also in September Alan B. Cohen, Sc.D., joined the Foundation as program officer. Dr. Cohen received his Sc.D. from the Harvard School of Public Health and since 1981 had been working at the Center for Hospital

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**To present as up-to-date a picture of staff changes as possible, this report covers the period through February 15, 1985.*

Finance and Management and the Department of Health Policy and Management at The Johns Hopkins School of Hygiene and Public Health.

Stephen A. Somers, Ph.D., joined the staff in October as program officer. Dr. Somers received his Ph.D. from Stanford University. Prior to joining the staff Dr. Somers served on the staff of the U.S. Senate Special Committee on Aging.

F. Catherine McCaslin, Ph.D., program officer, left the Foundation in March to assume a position at The University of Pennsylvania as project director of the National Study of Variation of Ancillary Services. Dr. McCaslin came to the Foundation in 1980 and helped to develop our grant programs in long-term care and research and development.

James P. Firman, Ed.D., senior program officer, left in May and moved to the Washington, D.C. area to establish a senior health care cooperative. Dr. Firman started at the Foundation in 1981 and was involved in our health-impaired elderly programs.

Philip J. Driscoll, M.B.A., financial analyst, who joined the Foundation in July 1980, left in June to become a consultant with Coopers & Lybrand in New York City.

Barbara H. Kehrer, Ph.D., senior program officer, left in July to become vice president of the Kaiser Family Foundation in California. At The Robert Wood Johnson Foundation Dr. Kehrer was involved in research projects related to grantee activities.

Senior program consultants

Jack Hadley, Ph.D., was appointed a senior program consultant for data research and analysis. Dr. Hadley is director of the Center for Health Policy Research Studies at Georgetown University.

Wendy Everett Watson, Sc.D., completed her assignment directing the Foundation's Teaching Hospital General Medicine Group Practice Program. At the time Dr. Watson was appointed senior program consultant in 1982, she was the vice president of ambulatory and community health services at Brigham and Women's Hospital. Dr. Watson has since assumed a position as program officer with the Kaiser Family Foundation.

Board activities

The Board of Trustees met five times in 1984 to conduct business, review proposals, and appropriate funds. In addition, the Policy, Finance, and Audit Committees met as required to consider and prepare recommendations to the board.

J. Warren Wood, III
Vice President, General Counsel, and Secretary

Application for grants

Application for grants

The Robert Wood Johnson Foundation is a private philanthropy interested in improving health in the United States. We are concentrating our resources on three well-defined needs in health:

- the need to improve access to personal health care for the most underserved population groups;
- the need to make health care arrangements more effective and care more affordable; and
- the need to help people maintain or regain maximum attainable function in their everyday lives.

To increase the potential impact of our grant funds within our three areas of interest, we have further defined our role to assist:

- development and testing of new and previously untried approaches to health care problems;
- demonstrations to objectively assess the operational effectiveness and value of selected new health care arrangements and approaches that have been shown to be effective in more limited settings; and
- projects designed to promote the broader diffusion of programs that have been objectively shown to improve health status or to make health care more affordable.

We give priority to proposed programs and projects that address regional or national problems. The one exception to this and our other guidelines is support for a small number of activities in New Brunswick, New Jersey, where the Foundation originated.

Policy guidelines established by our Board of Trustees will normally preclude support for the following types of activities: (1) ongoing general operating expenses; (2) endowment, construction, or equipment; (3) basic biomedical research; (4) international activities or programs and institutions in other countries; and (5) direct support to individuals.

Also, we do not support programs concerned solely with a specific disease or with broad public health problems, except as they might relate to our three areas of interest. The decision not to support such programs, worthy though they are, in no way implies a failure to recognize their importance. It is simply a consequence of the conviction that progress in the areas we have selected depends in large measure on our ability to

concentrate our funds. Unfortunately, even within our program interests and guidelines, requests have always exceeded our resources, and thus we are unable to support many deserving proposals.

There are no formal grant application forms. Applicants should prepare a letter that states briefly and concisely the proposed project as well as its objectives and significance; the qualifications of the organization and the individuals concerned; the mechanisms for evaluating results; and a budget. This letter should be accompanied by a copy of the applicant institution's tax exempt status under the Internal Revenue Code. Ordinarily, preference will be given to organizations that have qualified for exemption under Section 501(c)(3) of the Internal Revenue Code, and that are not "private foundations" as defined under Section 509(a). Public instrumentalities performing similar functions are also eligible.

Proposal letters should be addressed to:

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The Robert Wood Johnson Foundation
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Princeton, New Jersey 08540.

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