The Robert Wood Johnson Foundation Annual Report 1974

The Robert Wood Johnson Foundation Annual Report 1974

January 1, 1974, through December 31, 1974

The Robert Wood Johnson Foundation
The Forrestal Center, P.O. Box 2316
Princeton, New Jersey 08540

Library of Congress Card Number 73-80807

The Robert Wood Johnson Foundation

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.

Board of Trustees
Robert J. Dixson
Leonard F. Hill
Philip B. Hofmann
Wayne J. Holman, Jr.
Gustav O. Lienhard
William McC. Martin, Jr.
George H. Murphy
David E. Rogers, M.D.
Norman Rosenberg, M.D.
Hon. Dubois S. Thompson

Trustees Emeriti
John H. Hoagland
Hon. Klemmer Kalteissen

Counsel
John H. Myers, *Williams, Myers and Quiggle*
Washington, D.C.

Officers and Staff

Gustav O. Lienhard
Chairman of the Board
David E. Rogers, M.D.
President
Walsh McDermott, M.D.
Special Advisor to the President
Margaret E. Mahoney
Vice President
Robert J. Blendon, Sc.D.
Vice President for Planning and Development
Terrance Keenan
Vice President for Grants Management
William R. Walsh, Jr.
Treasurer
Alfred M. Sadler, Jr., M.D.
Assistant Vice President
Blair L. Sadler, J.D.
Assistant Vice President
Frank Karel, III
Director, Information Services
Linda Aiken, Ph.D.
Program Officer
Calvin Bland
Program Officer
David L. Cusic
Program Officer
Olga Ferretti
Program Officer and Assistant Secretary
Christine Grant
Program Officer
Francis Jones
Program Officer
John W. Murphy
Program Officer
Annie Lea Shuster
Program Officer
H. Thomas Luce
Controller
John M. Thoens
Assistant to the Treasurer
Philip J. Gallagher
Librarian
Barbara Lehan
Administrative Assistant
Edward H. Robbins
Administrative Assistant
Irma Sway
Administrative Assistant
Patricia M. Tusa
Administrative Assistant

John C. Beck, M.D.
Director, The Robert Wood Johnson Foundation Clinical Scholars Program
Jean E. Smith
Administrative Assistant

Senior Program Consultants

Richard A. Berman
Ann A. Bliss
James A. Block, M.D.
Robert H. Kalinowski, M.D.
Donald L. Madison, M.D.
Irwin W. Merkatz, M.D.
Marshall V. Rozzi

Contents

The president's statement

For many, if indeed not most Americans, private foundations remain mysterious, poorly understood entities. It is generally recognized that they often award funds for work in areas of social need or cultural affairs, but how they actually function, or the role they play in our society remains largely unknown.

The Robert Wood Johnson Foundation is now completing its third year as a national philanthropy concerned with American health problems. We are still very young and have much to learn about how to deploy our resources most effectively for the public good. We have emerged during a period when the value of private philanthropy is being questioned by many, and when foundations are under particular scrutiny. It is also a period of intensive review of approaches to health and medical care in the United States. These two concerns have caused us to think carefully about the place of philanthropy in health affairs in modern America, and about how we might handle our particular role most responsibly in these rapidly changing and contentious times.

We cannot and should not speak for foundations in general—we are too new at the game. But perhaps a distillation of our experience to date deserves sharing with others while it is still fresh. Our work has convinced us that the private charitable sector does have a significant role to play in matters relating to health care in this country, and perhaps a better understanding of even one foundation's thought processes—or how it is shaping its programs—may enrich the current dialogue.

Philanthropy and health affairs

Relationships between private and public funding of health needs have changed dramatically from those which existed in the early part of the twentieth century. At that time, philanthropic organizations were a major, often the principal, source of funding for new ideas in the field. In those earlier days, funds from philanthropic organizations were responsible for many of the gains in the health sector which are a source of real pride to health professionals and to Americans in general. Foundations and voluntary health agencies provided the major funding for medical research. The control of hookworm infestation, or the development of methods for virtually eliminating tuberculosis and poliomyelitis were, to a substantial degree, the result of philanthropic

underwriting. Similarly, following the foundation-financed Flexner report of 1910, private philanthropic funds enabled this country to take dramatic steps to improve the education of doctors. Private philanthropy also established public health as a separate discipline and helped launch new schools to serve this purpose. In addition, local philanthropic groups fostered the development of many of our community hospitals, including those serving such special groups as children, individuals with certain kinds of handicaps, or those from particular ethnic or religious backgrounds. In the same period, charitable groups were the source of monies which subsidized medical care for many who could not afford it, and philanthropic organizations also spearheaded the efforts to improve the health care of minority Americans. This was, and is, an impressive record for charitable organizations.

But since those early days of organized philanthropy, we have undergone a remarkable evolution in our social and economic system. The shift from a local, self-subsistent agricultural economy to a modern industrial nation, and the progressive urbanization of our population, have changed many things in American life, including the role of philanthropy. Since World War II, government support of medical research and health care has risen dramatically. For as our national abilities to modify and prevent disease improved, public expectations rose, and mounting public pressures led to an increasing number of public dollars being devoted to medical needs.

While private philanthropy and the federal government shared quite equally in their application of funds to national health problems in the 1930s, by 1973, federal government expenditures for medical care and health-related matters exceeded those of private philanthropy almost sevenfold. Even more dramatic, in 1973, private foundations, formerly major actors in the drama, spent only $732 million of the $94 billion—or less than 0.08 per cent of the total monies this nation applied to health and medical care needs.

This remarkable change in the ways Americans have elected to fund health and medical care has, of necessity, required careful reassessment of the role of philanthropy in this area. Indeed, many thoughtful people have asked if there is a role for private foundations in health when the dollar volume contributed by them is such a tiny fraction of the total. Our review has led us to believe that there is.

First—and most compelling—despite rapidly increasing national expenditures in the field, there is general agreement that the health care industry is simply not keeping up with the demands for health care, or able to distribute modern medical technology as effectively as people would wish. The public sector, of necessity, must put most of its funds into answering the immediate, pressing health needs of today. Almost 80 per cent of public funds go to delivering present-day care to our population—to addressing the problems of the here and now. These enormous demands on public resources have dictated that, as a

nation, we must spend proportionately less of our public funds on programs which might answer the health needs of tomorrow.

This fact of current life suggests that foundation dollars, if carefully and imaginatively allocated, might meet an important national need. The evidence suggests that foundations are doing so responsibly, in an important complementary manner. For in contrast to public agencies, foundations are collectively putting almost 90 cents of each of their dollars into programs which have the long-term goal of improving health care of the future. Thus, despite the lesser sums invested by foundations, programs which may supply better answers to the unsolved problems in medicine and health have been the principal beneficiaries of foundation awards.

There are, in our judgment, additional reasons for believing that foundation investments in medical areas are worthwhile at this time. The increasing involvement of government in our nation's health affairs, and the ponderous nature of massive public programs, is likely to restrict sharply America's long-term capacity to respond swiftly to the changing needs or rapidly developing technologies which affect health care. Public sector decision-making tends to move slowly and along generally accepted and traditional lines. This makes it very difficult for certain kinds of new or untested ideas to gain the support needed for an adequate trial. Also, because of the extraordinary costs incurred in the financing of health services, proper concerns about containing these costs will understandably prevent the public sector from moving very vigorously to upgrade current standards of medical care. It will also often not be able to provide opportunities for individualized, locally tailored initiatives in the health care area to emerge.

Clearly, a major strength of our nation has been the participation of multiple groups in our public affairs. In an area as complex, as diffuse, and as individualistic as health care, it seems particularly important to continue to preserve and foster pluralistic sources for funding. Without philanthropy as a participating partner in health affairs, most future innovations, new ideas, and scientific research would have primarily one possible source of support—the relatively centralized public financing mechanism. And the public sector is simply not designed for such a role in some areas.

While the federal record in support of basic biomedical research is superb, it has understandable problems in financing experiments which might change the ways we deliver medical care, or train health professionals, and the like. Here, government must await a politically developed mandate. Thus, a new idea stands a better chance of survival in a social system with many points of initiative and decision-making despite the apparent untidiness of such a system. In a world with an imaginative and responsible private philanthropy, a potentially important new idea in a sensitive area has many possible sources to turn to for a chance in the marketplace. While the government or

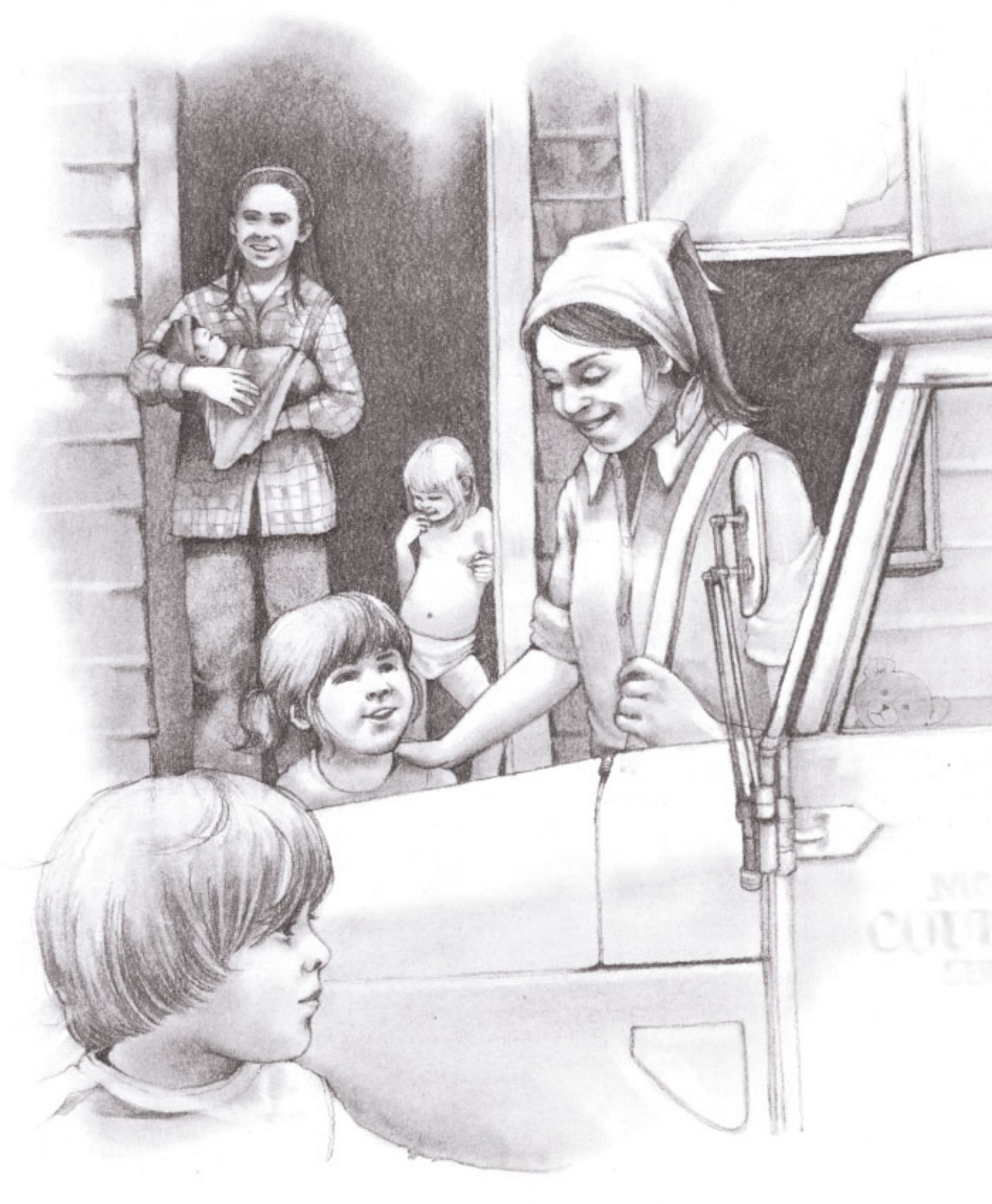
several foundations may say "no" to a particular idea, one foundation may support it.

Put quite simply, if the health care system of the year 2000 is to look different from the health care system of today, private philanthropy, and foundations in particular, must play an imaginative role. Only by having a group of institutions which are free to try routes quite different from those we require of our government, can we be assured that we are protected from the hazards of an increasingly centralized decision-making process.

Foundations can also provide a certain continuity of ideas, quite difficult for government. Key policy-making officials change with each administration or even during a single administration. For example, there have been 10 secretaries of Health, Education, and Welfare during the past 22 years. This often means that the permanent staff have to start over and over again with new policy formulations for new officials with new priorities. Thus, fine ideas sometimes get left behind, not because they are deemed worthless, but because they get laid aside during a change of administrators, and must consequently be rediscovered some years later. Foundations, with their special advantages of being able to look toward the future without such rapid turnovers in leadership, or as many of the pressing needs of the moment deflecting them, represent an alternative source of support for some long-range or visionary ideas which may add to the quality of American life for the generations who follow us.

If private philanthropy is lost to our nation, it seems unlikely that it can be resurrected. Thus, the preservation of private philanthropy—be it foundations, voluntary agencies, or simply individual giving—seems not only wise for the security of those who fervently believe in pluralism and private initiative, but at least prudent, even for those who currently doubt its importance.

But the preservation of foundations will not be guaranteed merely by extolling the virtues of pluralism, by detailing the important role foundations have played in the past, or even by presentation of reasoned arguments about how they can enrich our world of the future. Our demanding world of today forces many difficult priority decisions. Many worthwhile institutions must compete for a place in society. Thus I believe a large, nationally oriented foundation, such as this one, must become increasingly professional in the planning and execution of its program. We must better describe the nature of our thinking about the kinds of problems we are addressing. We must serve as more accessible sources of information and assistance to those we serve, and find better ways of reporting on the outcome of the endeavors we aid so that more can learn from our experiences. If the public is to make sound judgments about the role of foundations in modern life, foundations must provide more solid data about what they are doing, and how and why.



The Foundation's program

The question of how The Robert Wood Johnson Foundation could best contribute to America's capacity to deal effectively with unsolved problems in health and medical care were at the forefront of our concerns in January, 1972, when we began our transition to a national philanthropy. It was a time of increased national awareness and worry about the scarcity and costs of personal health services for those who are unwell, but not so sick as to require hospitalization. It was a time when the long debate about national health insurance seemed to be reaching a decisive stage. It was a time when the priorities of medical education and the post-graduate training of health professionals were being reexamined, and questions were being raised about the organization and deployment of physicians and other health professionals.

The early efforts of our trustees and staff were devoted to defining initial objectives. This process, and our selection of initial goals, was detailed in our 1972 Annual Report. Given the complexity of the health care field, the array of public and private constituencies involved, and the recognition that despite our size, our contribution to the national health effort would be small, it was agreed that we must identify and concentrate on a few selected areas of need, find talented people, and stick with them for a reasonable period, if we were to have a significant impact.

During that formative year, the staff and trustees outlined a program which had as its general goal improving ambulatory medical care in the United States. During the ensuing two years we have been acquiring experience with the program. Our funds have been awarded to groups and institutions working in three major problem areas: expansion and improvement of access to basic out-of-hospital general health care; development of better ways of measuring and upgrading the quality of general medical care; development of the information and resources needed to strengthen our national capacity for making wise health policy choices at local, state, and federal levels.

To date, our initial efforts seem to be reasonably targeted. We fully recognize that many unsolved problems are not represented in our current program, but some important ones which impair our national ability to deploy and utilize our health resources sensibly and equitably, are clearly within our areas of focus.

Defining and stating our objectives carefully has, I believe, helped us and those asking for our support. It has given us criteria, however imperfect, by which to select some for funding from the myriad of worthwhile ideas which reach us. But like boxing the compass, although the careful selection of a few initial objectives has allowed us to set forth on the journey, it has not told us how to get there. This is as it should be, for many thoughtful and dedicated people working on health affairs have differing views of how to proceed, and differing strategies for

moving toward these goals. Many routes look promising, and we have been able to serve as a source of enabling funds for a variety of diverse and different approaches designed to better individual medical care for Americans. Because our long-run effectiveness must be measured not by its benefits to the recipients of our funds alone, but by its benefits for a broader society, the programs we have supported have sought, in general, to address needs shared elsewhere in a particular region or in the country as a whole. We hope our grant recipients will show the way to others, so that what is achieved in one place can become the property of many.

This conviction has also led us to try to fashion ways to assess the broader effects of some of the projects and programs we support. While time consuming and expensive, this effort has forced us to ask more precise and more penetrating questions of our grantees and of ourselves. The process has made us vividly aware of large gaps in the data needed to yield information of sufficient precision or significance to permit others to build upon a pilot effort. It has led us to initiate studies to acquire this information, and to become more rigorous, more exacting, and more objective about what constitutes evidence. This is not to say that collection of solid data in the social areas to which we are devoting our resources is an easy matter, or that it can be done with anything like the precision which can be applied in the hard sciences. But this does not relieve us of the responsibility of trying to obtain relevant information, and hopefully to do so with increasing skill.

Investing in people

Our foundation works in a world of people. And we are deeply involved with persons with different goals, attitudes, biases, educational backgrounds, life experiences, and the delightful unpredictability of the human animal. Consequently, the data we must use are often soft, or impressionistic, and answers are often not as unequivocal or clear-cut as we would wish. So to move programs along, foundation staffs and trustees, like physicians, need training and experience in how to deal with uncertainty. They must make decisions on the basis of incomplete data, while at the same time making continuous efforts to upgrade and refine their information.

We have come to the view that our Foundation should have some of the characteristics of a responsible investment company, coupled with some of the characteristics of a scholarly research institute.

Traditional investment agencies are concerned with the risks involved in making investments and with the rate of return on those monies. If the risks taken by an investment company are excessive, or its investments poorly advised, stockholders lose money. On the other hand, if its investment policies are too cautious and the rates of return too low, the firm simply does not survive in the competitive market.

The Robert Wood Johnson Foundation is, in a sense, an investment

agency. We too are concerned with risks, but risks of quite a different nature than those of the business world. One is that a particularly productive idea, or a new or potentially better solution to a human problem will not see the light of day if we fail to recognize its potential worth. To avoid this takes an open mind, guarding against becoming doctrinaire, intense staff effort, substantial field work, and a basic confidence in human ingenuity. The major risk to our society, if the foundations collectively working in health affairs do not do their job properly, is that our national investment in new ideas or new ways of handling America's health problems may be too limited, or too poorly planned, and consequently, the health system of tomorrow will not be improved over that which we have today.

Obviously, a foundation can and should take risks in its grant making which may not be appropriate or possible for other investment groups. However, I believe we must be prepared to indicate why we felt the risk was warranted, and what the investment yielded in social return. How well did our expenditures permit people or institutions to respond to a particular problem, and what was gained from the effort? Perhaps the major difference between a foundation and a traditional investment agency is that we must take a national and ecumenical view of the problems we address. While in most business enterprises financial profits determine their survival, this is not the criterion for foundations. Although we must be financially responsible, our returns must be measured in how the programs we assist affect the lives of people for the better. Gains in this area must be our "profits."

To determine which problem areas look most susceptible to attack, or where foundation funds might be used most effectively, requires study and data collection. And, in such efforts, our activities bear some resemblance to those conducted within a research laboratory.

In days past, successful foundations, like brilliant clinicians, tended to encourage the belief that their effective functioning was intuitive—that some unteachable seventh sense tempered by time, experience, and wisdom permitted them to make reasonable judgments about the relative worth or importance of various proposals. To continue the analogy, as science entered medicine, it became increasingly apparent that the decision-making processes of even the most sophisticated of clinicians could be analyzed, understood, and indeed often taught to others in a logical manner. So it is, I believe, with decision-making within foundations. There is an intellectual and scientific content to effective foundation programs, and they can be analyzed, evaluated, and refined.

Just as the modern physician cannot function effectively without continuous updating of his information and appropriate backup by sophisticated technologic services, we find as a foundation that we cannot respond wisely or appropriately to the requests we receive without continual inputs of new information, research on which problems

look capable of solution by input of our funds, analysis of trends, and objective expert advice in our more complicated areas of activity. We must have the capacity to collect, interpret, and evaluate large amounts of data. We must do this in ways which can be respected and understood by those we serve. To do so requires that we develop a broad research and analytical capability.

Investment strategies

There are only a limited number of investment strategies which can be followed by a foundation. Basically they include:

(1) Investment in groups or institutions which need and wish to gain experience in dealing with a particular problem;

(2) Investment in programs to permit people to acquire new skills with which to tackle a particular problem;

(3) Investment in programs designed to increase national awareness or understanding of a problem; and

(4) Investment in new technologies.

The available information led us to feel in 1972 that our initial efforts should focus on the first three of these four investment strategies. We were, as a nation, having significant problems in delivering general medical care. Also, the technologic knowledge required to better distribute care at this particular time seemed available, but as a country, we were having trouble putting it in place. We also had too few physicians trained for, or comfortable with, general medical careers. There were too few health-oriented professionals with the skills necessary to tackle the sensitive and complex business of organizing and managing the health care system so that it would function properly for all involved. Further, those organizations, institutions, and the people who would clearly be called upon to lead the way, had simply not acquired sufficient experience in working with new systems to feel comfortable with them, or knowledgeable about their long range practicability. This suggested that our goals might best be served by concentrating on these areas.

Those who were developing new learning experiences for individuals who wished careers in delivering general medical care needed help. Others who had already acquired clinical skills needed support to learn new disciplines which would help them to design, organize, manage, or evaluate such new systems. A number of groups and institutions needed funds to permit them to establish, test, and gain experience with new systems of health care. Thus, we have been heavily engaged in efforts which might be termed "people experiences," or "institutional experiences," and this has led us down two general avenues in making grants.

One has been gradual and developmental. It has consisted of making single grants to institutions and organizations that have sought our help for programs within our area of focus. This activity has occupied

most of our time and effort during this formative period. It has brought us in contact with many people, with many new ideas, and has greatly increased our appreciation of the complexities involved in the deceptively simple problem of "improving access to general medical care."

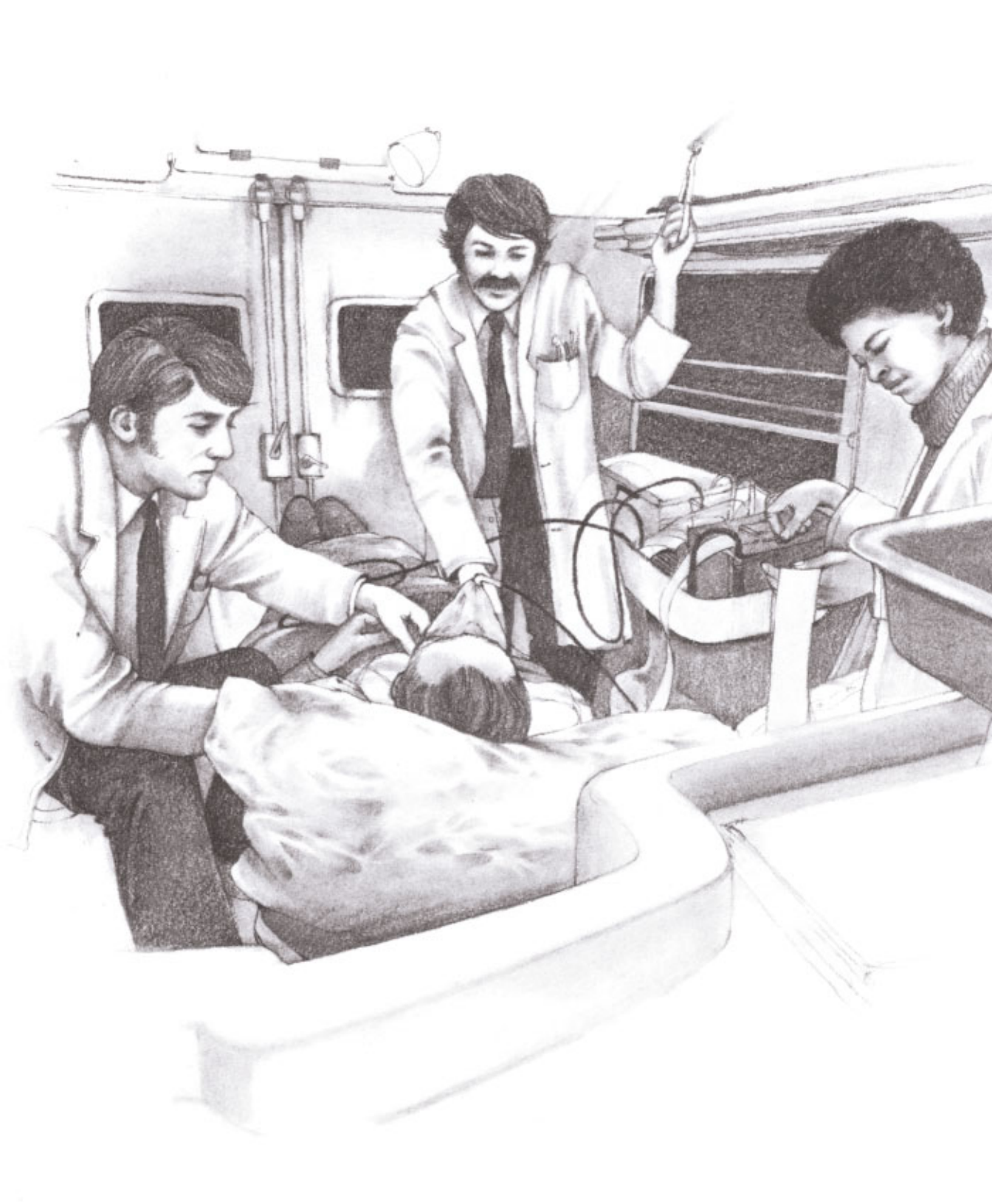
This particular form of grant making has also made us recognize that in a number of instances, multiple groups or institutions simultaneously wish to attack the same problem in different regions, using their particular resources, or their particular circumstances, in different, yet quite similar ways. This kind of broadly voiced interest in a particular problem has led us to develop a series of one-time grants, nationally announced, and awarded to a number of institutions participating in a broader national effort directed at a particular need. These are foundation-initiated programs in areas where a certain critical level of activity seems needed to gain experience with, or to demonstrate the worth of, a particular approach.

There has been an additional and compelling reason for attempting selected programs on a national scale. We feel an increasing responsibility for opening the Foundation's door to groups that would not ordinarily come to our attention. In our present world, many people simply do not know how to relate to their institutions, and here foundations are no exception. In certain ways this inability of people to relate to them has been the Achilles' heel of foundations. It has caused many to feel that foundations are elitist or arbitrary in their awards. Because of unfamiliarity with foundations in general, or a lack of understanding of our mission in particular, many who might make important contributions to improving health affairs do not find their way to us. We have undertaken national invitational or competitive programs to help overcome this problem.

Basically, we are attempting to weave our awards into a logical program, which will add to our "people experience" via each of these avenues: by single awards to institutions or groups that approach us; by national programs designed to encourage groups or regions to participate with us in a new venture.

Single awards contributing to "people or institutional experience"

In response to proposals brought to us, we have supported new primary care or family-oriented residency programs at 12 different institutions to train more physicians who will elect to try general medical practice careers. Programs to prepare nurse practitioners for expanded roles in general ambulatory care, and programs to train physician assistants for primary care roles in conjunction with physicians have been aided by our funds in several institutions. In an effort to be sure that new practice opportunities are being simultaneously established so that these professionals will have appropriate settings in which to apply their skills, we have aided community groups and institutions which are establishing primary care group practices in underserved urban and



rural areas in Nebraska, Kentucky, Ohio, California, Illinois, and New Hampshire. With our funding, regional primary care networks staffed by nurse practitioners working closely with physicians have been planned and organized in Utah, California, Tennessee, Connecticut, and Kentucky. A program to train managers for new forms of group practice or health maintenance organizations has been started at the Wharton School of the University of Pennsylvania in cooperation with the Group Health Foundation.

We hope that such awards, made in response to requests we have received, will provide a new cadre of health practitioners at various levels who are knowledgeable about and trained for practice in ambulatory settings, and know how to manage them. Our grants for testing new ways of delivering care should help assure that there will be some different kinds of practice opportunities in place which can use these new health professionals, and increase the options available to them in applying their skills.

We have coupled with these programs certain information gathering and research studies which we believe will help to fill gaps in our national understanding of where changes would be most effective in improving health affairs. Some of these studies are being conducted by our staff. Still more are being carried out by other groups with our support. They address questions such as: How effectively are we meeting the health needs of our children? What options are available to the nation for improving school health care? Just how difficult is it for people to find a primary or general care physician, and can this difficulty be quantified so that efforts to improve it can be measured against an appropriate baseline? How much "primary care" is actually being provided by those who are labelled "specialists"? Can more public education about health change behavior and lead to improved individual health? We hope these studies will give us and others a clearer view of where to direct resources.

Invitational programs contributing to "people or institutional experience"

Programs designed to encourage a number of regions or institutions to apply for funds to work on a particular problem take many months in their planning, development, and initiation. These programs have required consultation with experts and professional groups external to the foundation in their formulation and design. In an effort to keep our internal staff small, an outside organization has often been asked to assume responsibilities for implementation and day-to-day management of a particular program.

To date, we have launched seven national programs of differing size and complexity. Each is directed at giving people and institutions the opportunity, time, and funding needed to develop experience in an area of health endeavor needing broad attention. Hopefully, promising efforts will be replicated elsewhere. I can illustrate with a few examples:

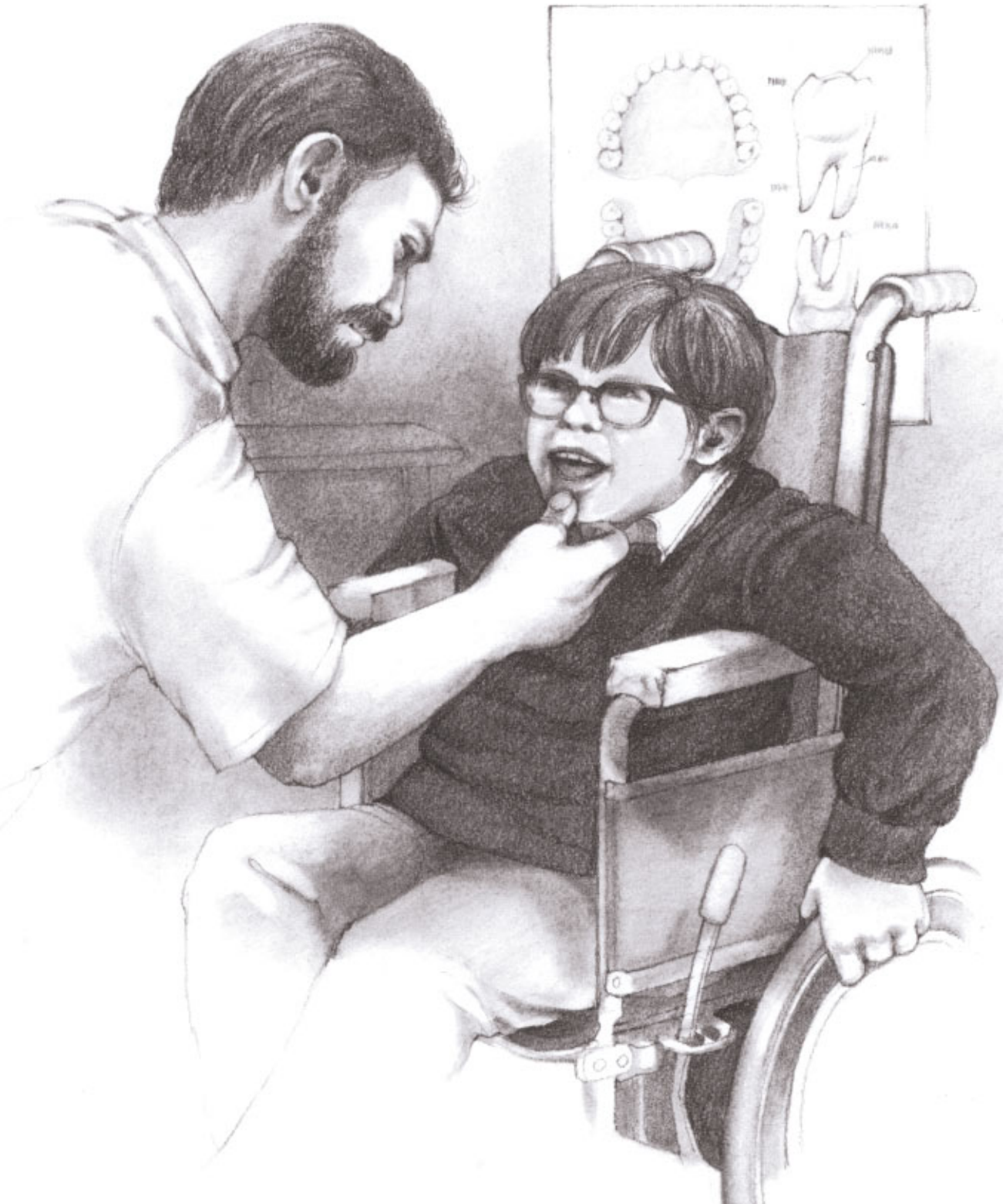
Emergency medical response systems
Evidence that regionalization and organization of emergency response systems could significantly improve emergency care led to the development of a national competitive program. Guided by an advisory committee based at the National Academy of Sciences, this program enabled 44 regions to begin forming new emergency medical service networks. These regional networks are designed to cut down the time it takes to get medical help to acutely ill or injured individuals, and to provide more assurance that they will be taken to a medical facility which is appropriately equipped to deal with their particular problem. A study of the effects of this program on subsequent disability or death is now under way by the Rand Corporation with our support. This study should yield important information for future national planning in this area.

Regional networks for perinatal care
Similar evidence that the technology was available and that regionalization might improve the outcome of pregnancies for women with special risks for themselves or their infants has led us to inaugurate an invitational program which will permit a limited number of regions with university hospital-based perinatal units to develop comprehensive high-risk pregnancy program networks. A simultaneously launched evaluation program based at the Health Services Research and Development Center of The Johns Hopkins University will, we hope, give this nation the evidence it needs to determine whether such programs should be replicated and adopted on a broader national scale.

Community hospital-sponsored group medical practices
The increasing problems faced by our community hospitals, which now often serve as personal physician substitutes in their over-crowded emergency rooms and outpatient departments, has prompted the development of a national program which will permit some of these hospitals, at least one in each state, to organize hospital-linked primary care group medical practices to better meet the ambulatory general medical needs of those they serve in a particular region.

Leadership training for health professionals
Two nationally oriented programs are permitting young men and women to acquire skills and experience not offered in traditional postgraduate medical training programs. Robert Wood Johnson Foundation Clinical Scholar programs are now operating in 11 academic institutions. They are designed to help young physician-clinicians acquire special skills in certain non-biologic disciplines such as epidemiology, demography, economics, management techniques, and other related fields which can better prepare them for leadership in new and more complicated systems of health and medical care.

The Robert Wood Johnson Fellowships in Public Policy program was



developed under the auspices of the Institute of Medicine and the American Political Science Association. This program, to which all academic health centers can submit nominees, offers a small number of mid-career health professionals the opportunity to have an intensive, well-planned year of study and work in the country's national health institutions, and in staff roles with members of Congress in Washington, D.C.

These and other national programs have the advantage of being open to a wider group than commonly receive foundation assistance, and are believed to be an even-handed approach to problems of national concern where many are interested in their solution. Some of the national programs have also had an important "ripple effect" which may help extend their impact beyond what we are able to support. When an institution, an organization, or a region has the opportunity to plan for participation in a particular program, the relationships formed sometimes lead to agreements about how to improve health care in an area even if the Foundation is unable to fund it. For example, 250 applicants went through the cooperative planning required to apply for Foundation assistance to improve emergency medical systems within their regions. This required the sustained efforts of many groups within each region. While the Foundation was able to fund only 44 of the 250 applicants, a number have indicated that the process of planning led them to recognize what they could do to improve their emergency medical care on their own, and they have gone ahead to establish such a program with locally available monies.

Our national programs have also tended to produce a greater diversity of high quality proposals. Many have been received from people or institutions previously unknown to the Foundation, and thus we have gained acquaintance with many new ideas and people of great talent who otherwise would not have come to our attention.

Internally, the development of national programs has required the collection of large amounts of information, careful articulation of goals, and work with many groups and individuals who have given generously of their time and effort in helping us to develop such programs. National ventures have also required that the staff and trustees work through difficult policy questions together, and this has added coherence to our internal functioning.

The time and money involved in these larger programs also permits adding other dimensions to a national effort which cannot commonly be accomplished with single grants. For example, in some areas it is clear that a "state of knowledge" or "how-to-do" manual is needed if the multiple groups involved are to be spared costly or inappropriate starts in their activity. Thus, in preparing for the community hospital program, a Columbia University group is preparing a manual on previous community hospital experiences with ambulatory group practice

programs for use by applicants to the program. Sometimes a national program makes it appropriate to get all of those involved together in common work sessions to share experiences. The emergency medical systems program was followed, for example, by a series of four regional workshops to which all who had applied were invited. These workshops allowed sharing of expertise, successes, and failures which has helped each region to better plan its individual approach to the problem. Similarly this focus on emergency services led to the funding of a group at Public Technology Inc., working with the University of Pennsylvania, to develop a technical assistance capacity to help those planning regional emergency networks. We have also supported a program at Johns Hopkins University to train residents for teaching careers in emergency medicine.

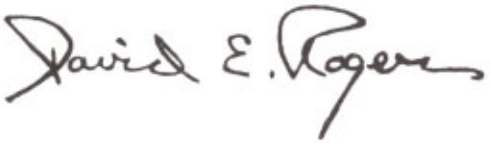
Perhaps most important, these national efforts which involve many diverse groups with different approaches are permitting us to develop carefully planned objective studies of the program's success in improving the lives of the people they touch. As I have noted previously, we feel that this particular function will in many ways determine our long-term effectiveness in health affairs, but it is a sensitive and delicate area in which to work. Those that we support are often working in difficult high risk areas, and failures of some individual programs are to be expected. These human efforts and those who attempt them need encouragement, not criticism. But large national programs can be evaluated and reported in ways that can help this nation make better decisions about health programs without discouraging or disparaging individual programs. We are increasingly a society that demands solid evidence of the effectiveness of a particular innovation before it will be replicated, and we are trying through our national programs to provide such evidence. Thus, we feel that our nationally announced invitational or competitive programs should enrich our abilities to be of aid to others who are responsible for planning health and medical care for the future.

There are two important forces which work against change in our social institutions. One is simple ennui—the old ways are known and comfortable even if unsatisfactory. The other is fear—fear that a new solution may raise yet other more troublesome difficulties or turn out to be worse than what went before. And here, perhaps, a foundation can play a unique role, and can sometimes permit constructive change to occur. We can offer people, institutions, and communities the opportunity to test a new approach and then give others the chance to prod it, examine it, and see if it fits their particular set of circumstances, and whether it can have yet broader application. Fear of the new is sometimes allayed by taking an idea out of the abstract and seeing it in operation.

Our activities to date lead us to feel that although a foundation plays

only a modest financial role in an area as costly and important as the kind of medical care our nation delivers to its citizens, it can nevertheless enrich the quality of the effort expended. To do so we have had to concentrate on just a few targets, setting aside others of equal importance. We are approaching these targets by two routes. First, by selecting from a large number of proposals brought to us, a few which we can support. This is a difficult process, for the proposals coming to us represent the best thinking of hundreds of people, and we are fallible humans working in largely uncharted areas in selecting among the projects. Complementing this approach has been the development of selected national programs which cannot be inaugurated by an individual investigator or an individual institution, and here we can be an enabling agent. Both approaches are aimed at providing opportunity for people and institutions to develop new ways of approaching problems of medical care, and for field trial of systems that appear to have potential advantages for the future.

It is our conviction that we have, within the minds and vision of those working with health affairs, solutions to some of the important problems which vex our nation today. We hope we are helping some to develop and test their ideas in real world situations.



Description of selected grants

Description of selected grants

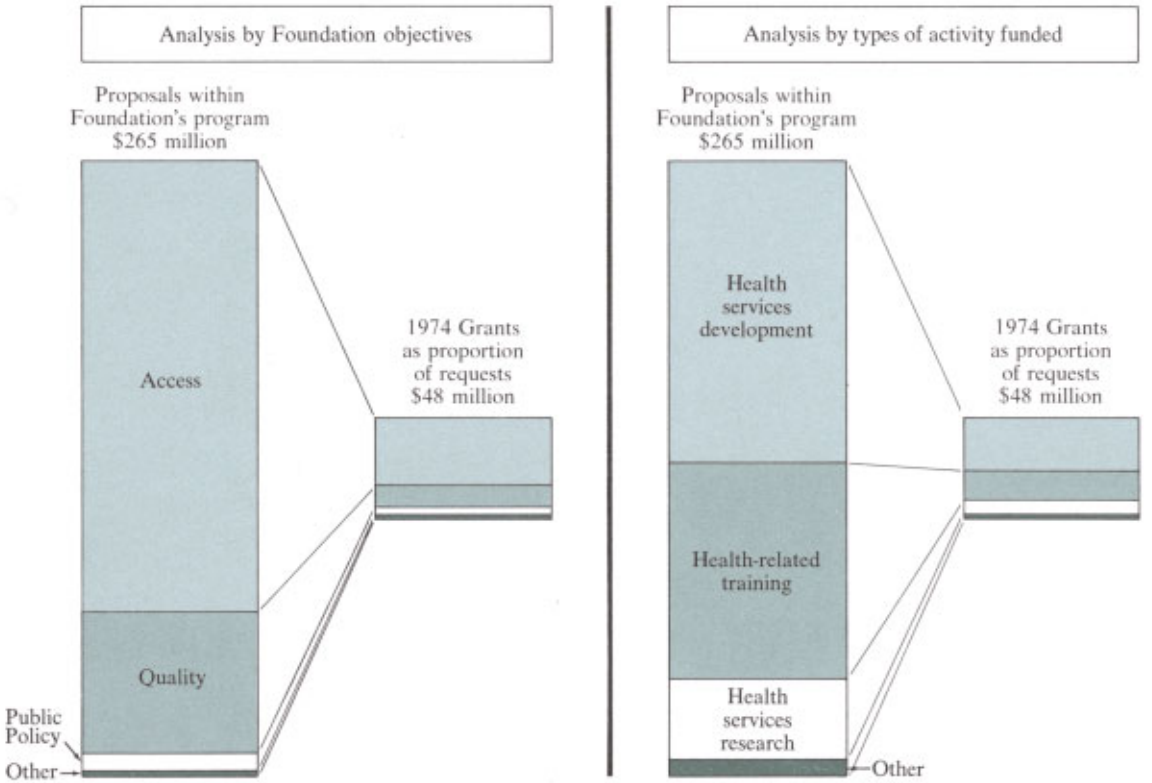
During 1974 the Foundation made 117 grants, which represent a commitment of $48 million. In addition, plans were announced for a $30 million program to enable a select number of community hospitals to develop hospital-linked primary care group medical practices. Grants under this program are expected to be made in 1976 or later. In 1974, projects to improve access to general medical care received $32.2 million, or 67 per cent of these funds. Projects to improve the quality of health care received $12.6 million, or 26 per cent. Projects in health policy, and research and evaluation studies received $2.4 million, or 5 per cent. The remaining $766,000 went to other projects, including those in the New Brunswick, New Jersey area where the Foundation maintains a historic and continuing interest.

Under these major Foundation objectives, grants were made in support of the three kinds of activities described in the preceding section: to assist groups and institutions wishing to gain experience with new ways of delivering ambulatory care; to help people acquire new skills in ambulatory health care programs; and to increase national awareness and understanding of broad problems in health.

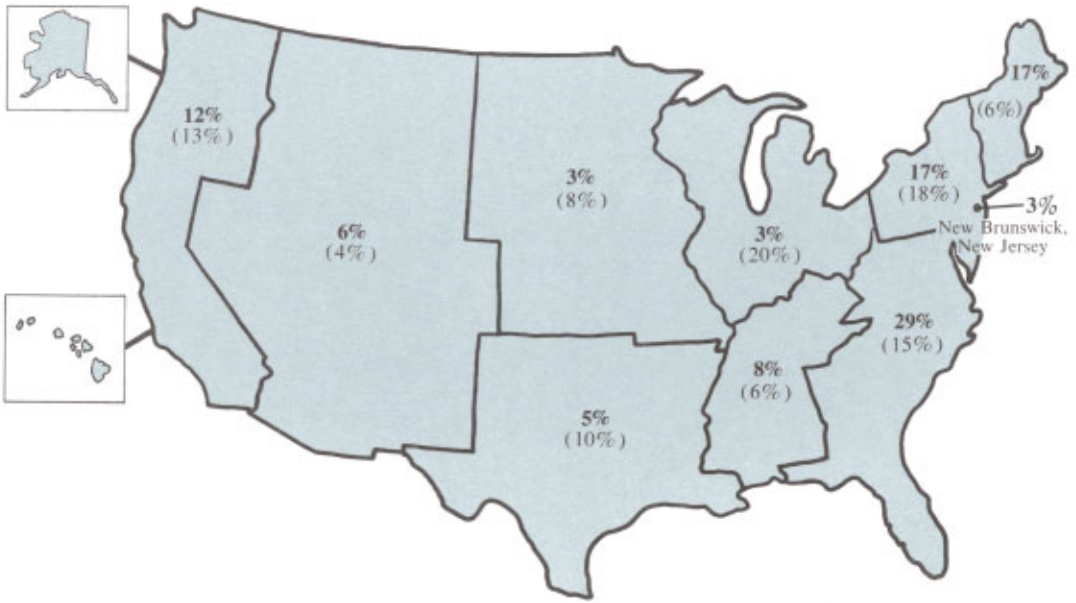
Those grants described on the following pages have been grouped according to these activities. They have been selected from among the 1974 grants to give an overview of projects funded during the year. A complete listing of grants by institutional recipient begins on page 52.

The Foundation received approximately 3,600 requests, written proposals, and inquiries during 1974. The written proposals which addressed problems within the Foundation's program objectives would have required more than $256 million to implement. The accompanying charts indicate that the Foundation's resources could support only about 18 per cent of the funds requested, and show the geographic distribution and the types of institutions receiving support in 1974.

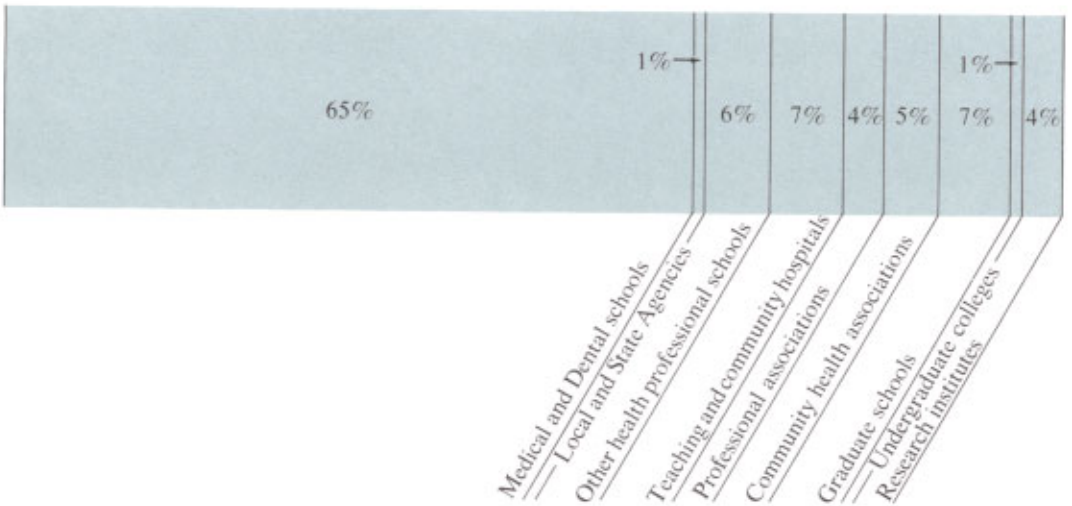
Analysis of the Foundation's 1974 grants



Distribution of Foundation's 1974 grants by geographic region.
Percentage in parenthesis indicates percentage of total U.S. population in a region.



Distribution of the Foundation's 1974 grants by type of institution
As noted in the preceding charts, most of these grants are for service programs.



Projects to gain experience with new ways to deliver services

The Foundation has supported the development of a number of primary care group medical practices, especially in communities where basic medical services are scarce. These practices include free-standing institutions sponsored by community organizations, and those established by hospitals or academic medical centers. They typically include a mix of family practitioners, internists, pediatricians and other primary care specialists, plus a full-time administrator. In many of these practices, physicians and new health care professionals, such as nurse practitioners and physician assistants, share patient care responsibilities.

Free-standing group practices

Among the free-standing groups we supported in 1974 is the Morehead Clinic in northeast Kentucky. The physicians and staff of the Clinic are working with residents of several communities in this rural area to develop a network of ambulatory care centers. The Clinic assists the communities to recruit physicians, trains non-physician staff, and helps them secure funds for new facilities. Young physicians from the state's medical schools will be given an opportunity to work in this project through a state-sponsored training program.

The Rural Health Care Association in Denver, Colorado is also helping rural communities to meet their health care needs. The Association provides physicians and health centers in Colorado and five adjacent states the management and medical support services they need to establish rural practice units. We are also supporting the efforts of La Clinica del Pueblo de Rio Arriba to develop a mother and infant care program for a remote section of New Mexico.

The Foundation also assisted a number of programs in urban areas. As an example, the Roxbury Dental and Medical Group, a multi-specialty group practice, is expanding a health program begun three years ago by residents of the Roxbury-North Dorchester section of Boston. The expansion will help the practice meet the medical needs of 21,000 residents in the area. The nearby New England Deaconess Hospital, and its head of community medicine, helped to organize the program.

In Hartford, Connecticut, Community Health Services, a nonprofit physician group practice, is working with the Greater Hartford Process, an urban renewal organization, to develop a health care system for the north Hartford area. A series of neighborhood centers staffed by nurse practitioners backed up by the group practice will provide basic medical services.

The Foundation has also supported a study to determine the role of nurses as primary care providers. The study is being carried out in a nurse-initiated health center sponsored by Adelphi University and Molloy College, and serves some 400 families in a housing project in Freeport, Long Island.

Because prepaid group practice plans can offer opportunities for training physicians in ambulatory care, the Foundation has assisted a limited number of medical center affiliated programs. In 1974, these included new programs by Georgetown University's Community Health Plan and the Harvard Community Health Plan, both of which serve communities lacking adequate access to general medical care.

Hospital-sponsored ambulatory programs

In recent years, the hospital emergency room and outpatient departments have become a major source of general medical care for ambulatory patients. As a result many hospitals are broadening their roles. The following projects illustrate the kind of ambulatory care projects community hospitals and academic medical centers started in 1974.

The Tuskegee Institute plans to utilize teams of nurse practitioners working from a mobile van to make an initial assessment of the health

needs of families in a three-county area of central Alabama. The nurses will schedule appointments with a group of family physicians at the Institute's John A. Andrews Memorial Hospital, and assume responsibility for the follow up care prescribed.

In Memphis, Tennessee, the City Hospital and the Memphis-Shelby County Public Health Department are working with the University of Tennessee to organize a regional network of health clinics staffed by nurse practitioners, and backed up by physicians, pharmacists, and dentists. This program will provide basic services to a four-county area with a population of 780,000 persons.

The Appalachian Regional Hospital in Hazard, Kentucky has begun a program to provide home-based care to expectant mothers, infants, and young children of hard-to-reach rural families. Nurse practitioners and specially trained aides travel to the mountain hollows on regularly scheduled visits to examine infants and provide instruction on nutrition and child development. The outreach team is backed up by a pediatrician, obstetrician, and a pediatric neurologist based at the hospital.

In Colebrook, New Hampshire, the 14 rural communities that make up the Upper Connecticut Valley raised funds for the construction of a hospital in hopes the new facility would attract new physicians to replace those that had retired. When this failed, the remaining doctors in the area formed a primary care group practice under the hospital's sponsorship. Our funds will assist the practice to become operational.

In a suburb of Baltimore, Maryland, the Franklin Square Hospital and the Public Health Department have planned a system to assign health department patients to a physician at the hospital who will assume continuing responsibility for their care. The health department and the hospital will use a common medical record, and thus provide a coherent system of primary, ambulatory care for a largely low-income population.

The Foundation also announced plans for a $30 million program which, when fully implemented, will give selected community hospitals and their medical staffs an opportunity to improve primary medical care in their communities. This national program will provide four-year non-renewable grants to approximately 60 community hospitals, hopefully at least one in each state. Each will establish and sponsor a primary care group medical practice which will serve as a single identifiable source of continuing ambulatory care for the whole family.

Among academic medical centers, Children's Hospital of the University of Pittsburgh expanded a regional child care program with Foundation funds this year. The Pittsburgh program includes a community hospital-based training program for pediatric residents, a telephone consultation and referral service for local practicing physicians, a pediatric nurse practitioner training program, a poison control and child abuse center, and the first of a series of regional intensive care centers for newborn infants. The program involves community hospitals, local physicians, and state and community health service organizations in western Pennsylvania, eastern Ohio, and northern West Virginia.

The Columbia University College of Physicians and Surgeons in New York, and Children's Hospital in Washington, D.C. received grants to plan similar programs for their areas.

Two years ago, Beth Israel Hospital in Boston, one of Harvard University's teaching hospitals, replaced its outpatient department with a hospital-based primary care group practice. It was a significant departure from the pattern of care provided in most academic medical centers. With Foundation support this year, Beth Israel has begun to develop an evaluation and reporting capability which will provide information on the cost and effectiveness of this new system, in a form useful to

other hospitals developing teaching practices in ambulatory care.

Regional systems of care

The Foundation has supported two programs to organize ambulatory care services on a regional basis: one is in emergency medical services; the second is a perinatal program for the care of pregnant women and their newborn infants.

The program to regionalize emergency medical response systems was described in the 1973 Annual Report. Under this program, forty-four regions of the country received grants in 1974 for the organization of regional emergency medical response programs. The National Academy of Sciences in Washington, D.C., which has been involved in emergency medical care planning for a decade, is responsible for the administration of this program.

During the development of this program, the Foundation found that many of the 260 applicants needed assistance to deal with the complicated process of coordinating emergency services among municipalities, counties, and police and fire departments. To help communities with such needs, the Foundation supported the development of a technical assistance capability by Public Technology, Inc., a Washington, D.C. nonprofit organization which helps state and local governments with specific problems requiring technologic intervention. In addition, the American Medical Association worked with the Foundation to conduct a series of four workshops on emergency medical services which dealt with technical problems in organizing efficient emergency systems, including an analysis of the appropriate communications equipment; and the latest approaches to training medical dispatchers and ambulance personnel.

Evidence that the effective application of recent technologic advances could significantly improve the outcome of high risk pregnancies so that the infants not only survive, but have much better chances for both mental and physical growth, led the Foundation to develop a program for the organization of regional perinatal service networks.

Under this program, all pregnant women in a participating region will receive initial care close to home, and those with special problems will have access to more complex care, if the situation requires. A university-based medical center will be at the hub of this regional network, providing highly specialized care for those at particular risk.

Special systems of care provided by non-health institutions

The health of school-age children has been surprisingly neglected, and the Foundation is supporting several programs which join schools and the medical care system in common efforts to meet the special health needs of children.

The Galveston, Texas schools and the University of Texas Medical Branch there are collaborating in a project which involves school nurses, community health aides, and the University's pediatric outpatient clinics. Under this program, when a child is referred by the school nurse to a physician, a community health aide works with the parents to see that the child obtains the necessary care. The use of a common medical record by the schools and the University will facilitate the early identification and treatment of health problems by organizing in one place the screening and other health data available. These efforts should assure that health problems detected in the schools are resolved.

The Brookline, Massachusetts Public Schools are in the midst of a seven-year effort to demonstrate that many of the health and learning problems that contribute to widespread school failure in this country can be prevented, and the need for expensive remedial services reduced. Support for this project, which was described in the 1972 Annual Report, was renewed in 1974. The Brookline project is designed to determine what role the pre-school environment, family relationships,

and health care play in determining the subsequent abilities of a child to succeed in school. The Children's Hospital in Boston is cooperating with the Brookline schools on the project.

Programs to help physicians and other health professionals acquire new skills

The Foundation supported a number of projects in 1974 to provide physicians, and the leaders of academic medical centers and group practices, the tools and skills they need to manage complex health care organizations. We also supported programs to provide young physicians clinical experience in ambulatory care to complement their hospital-based training.

New management skills

In 1972, the Foundation initiated the Clinical Scholars Program as an effort to give young physicians already trained as clinicians an opportunity to acquire new skills in non-biological disciplines. Under this program, which has been described in previous Annual Reports, a limited number of medical schools are providing physicians training in economics, epidemiology, statistics, the behavioral sciences, law, and the management sciences.

With the selection of four medical schools in 1974, this program reached the authorized size of eleven schools. Programs are now under way at Case Western Reserve University; Columbia University; George Washington University; Johns Hopkins University; McGill University; University of Pennsylvania; Yale University; University of North Carolina; University of Washington; University of California at Los Angeles; and a joint program by the University of California at San Francisco and Stanford University. Administrative offices for this program are at the University of California at San Francisco, under the direction of Dr. John C. Beck.

We are also supporting a program to provide the chief administrative officers of academic medical centers an opportunity to develop the new skills they need to manage their increasingly complex institutions. The program is sponsored by the Association of American Medical Colleges in Washington, D.C., in collaboration with the Alfred P. Sloan School of Management at the Massachusetts Institute of Technology.

Two additional programs are providing managers of group medical practices training in the administration of ambulatory care centers. The Center for Research in Ambulatory Health Care Administration in Denver, Colorado, and its parent organization, the Medical Group Management Association, have organized a series of workshop programs on the start up and operation of group medical practices. The Wharton School at the University of Pennsylvania has developed a 15-week program to train managers for prepaid group practice plans, which are becoming a more frequent way of delivering medical service. The Group Health Association of America, the professional association for prepaid group practices, is participating in this program.

Health Care Management Systems, Inc., a nonprofit management information consultant firm in Utah, is providing physicians and group practice managers assistance in setting up systematic procedures to record, retrieve, and use the information they need to monitor staff productivity, quality, and the cost of care. The Foundation is also supporting the efforts of the American Arbitration Association to introduce a set of internal management procedures for ambulatory health care organizations.

New clinical skills

Part of the Foundation's attention has been directed toward programs to attract more physicians and other health professionals to careers in general medical practice. Many of these projects provide for the joint training of physicians with nurse practitioners, physician

assistants, or other non-physician health practitioners in family-oriented primary, ambulatory care practice.

In the past two years, 12 medical centers have initiated such programs with our support. Those receiving Foundation assistance this year include the Boston City Hospital, in collaboration with the Boston University School of Medicine; the University of California at San Francisco; the Charles R. Drew Postgraduate Medical School in Los Angeles; Harvard University; the University of Missouri, Kansas City; and the University of Virginia.

These programs involve a major commitment by these medical centers to training for primary, ambulatory care. The department of medicine at Harvard University, for example, has announced a goal of having nearly one-third of its graduate physicians in the primary care training program. The Harvard program includes three of Boston's major teaching hospitals—Massachusetts General Hospital, Peter Bent Brigham, and Beth Israel, as well as two community hospitals—Mt. Auburn and Cambridge City Hospital; community health centers; and a prepaid group practice organized by the Harvard Community Health Plan.

The Alfred P. Sloan School of Management at the Massachusetts Institute of Technology is developing a curriculum which will introduce physicians and other health professionals to the decision-making skills and interdependent roles involved in sharing patient care responsibilities. This team approach to care appears to be particularly important in carrying out routine diagnostic and therapeutic procedures, performing follow-up studies, and monitoring the treatment prescribed, particularly for patients with chronic care needs.

Although the number of non-physicians trained to assume many of the functions normally performed by the physician in ambulatory care is increasing, job functions and performance standards are not well defined. The National Board of Medical Examiners, with the American Medical Association and other professional groups, is developing professional standards for these new health practitioners through a certification program. The certification will be carried out by an independent commission composed of leaders in medicine, nursing, and physician assistant programs.

The Foundation continues its efforts to increase the number of minority students interested in medical careers. In 1974, we renewed support for the Student National Medical Association's successful preceptorship program which enables minority medical students to work with practicing physicians in inner-city and rural areas, and supported the expansion of Tulane University's program to identify, during their college years, talented minority students with an interest in medicine. The Tulane project is a collaborative effort involving nearby medical schools and undergraduate colleges, and provides minority medical students the special counseling and courses they need to succeed in medical school.

In 1973 we announced a program with the American Fund for Dental Health to provide young dentists the clinical training experience they need to care for the physically and mentally handicapped. Under this program, the eleven dental schools listed on page 87 developed plans in 1974 to introduce a carefully planned program to provide special dental services to patients from all age groups suffering from a wide variety of crippling conditions.

Programs to increase national understanding of health care problems

The Foundation has supported a select number of programs designed to deal with the problems of decision-making in health policy and with the lack of adequate information on policy.

Health policy planning

In 1974, we supported the planning and development of a health policy center at Georgetown University in Washington, D.C. This center will function as an information clearinghouse about health policies and programs at the state and local level, and will provide independent analyses of policy options on issues which state and local government leaders identify as problem areas. The decision to focus on state and local issues comes at a time when the federal government is looking increasingly to state and local governments to implement national health policy and to administer federal funds for health services. Our support of such policy centers is limited to the Georgetown program and the health policy center at the University of California at San Francisco, which we supported in 1973.

The Health Staff Seminar, an educational program of George Washington University, provides professional staff members from both the executive and legislative branches of the federal government a forum for the exchange of information on health care problems confronting American communities. These seminars, developed and run by the participants, provide a variety of opportunities to explore new concepts, to examine critical health issues in detail, and to meet a cross section of leaders in the non-federal health community. The Foundation also provided partial support to enable the Sun Valley Forum on National Health, Inc. to plan a series of programs on health policy issues.

Research and evaluation studies

A limited number of research efforts are being supported to gather and analyze the data needed to deal with critical issues in primary, ambulatory care. These program-related studies will provide an understanding of the background of a specific issue, previous attempts to deal with it, and alternatives for future action.

Under this program, the University of Southern California has begun a national study to determine the amount of primary care provided by different medical and surgical specialties, and the University of Chicago is developing a project to measure the specific problems people face in securing medical care. The Leonard Davis Institute of Health Economics and the Center for the Study of Emergency Health Services at the University of Pennsylvania have begun a project to identify the economic and financial issues involved in organizing and managing emergency medical service systems. The Health Economics Research Center at the University of Wisconsin is examining the kinds and degrees of patient care responsibility that are delegated to new health practitioners. The study will involve a number of different practices in which physicians and non-physician associates share responsibilities.

The Foundation is also supporting the development of independent assessments of several projects it has initiated. Two projects to evaluate the impact of the Foundation's programs were begun this year. The Educational Testing Service in Princeton, New Jersey will assess the Foundation's program to train dentists in the care of the physically and mentally handicapped, and the Johns Hopkins University Health Services Research and Development Center will evaluate the Foundation's program to establish a series of regional perinatal networks for high risk pregnancy care.

Financial statements

Introduction to Statements

The annual financial statements of the Foundation appear on the following pages. A listing of marketable securities other than Johnson & Johnson common stock held by the Foundation at December 31, 1974, appears on pages 47 through 51, and a summary of grants will be found on pages 52 through 89.

At January 1, 1974, the Foundation owned 9,549,975 shares of Johnson & Johnson common stock. During the year, 200,000 shares were sold and 17,852 shares were exchanged with Princeton University for land in Plainsboro, New Jersey, on which the Foundation headquarters building is under construction. This left a balance in the portfolio at December 31, 1974, of 9,332,123 shares.

The income from investments for the year ended December 31, 1974, was $23,154,399, compared with $18,731,787 for 1973. Deductions from this income for investment expenses and provision for Federal excise tax amounted to $1,081,955 in 1974 and $901,295 in 1973.

The total of grants authorized and administration expenses during 1974 was $49,901,646, or $27,829,202 in excess of net investment income of $22,072,444. The excess of the total of grants authorized and administration expenses over net investment income for 1973 was $36,772,312. Over the three-year period since the Foundation became a national philanthropy, the cumulative excess of grants and expenses over net investment income has amounted to $99,547,145.

The assets of the Foundation at December 31, 1974, based on quoted market values, were $970,653,746 compared with $1,301,947,544 at December 31, 1973.

William R. Walsh, Jr.
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, 1974 and the related statement of investment income, expenses, grants and changes in foundation principal for the year then ended. Our examination was 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. We previously examined and reported upon the financial statements for the year ended December 31, 1973.

In our opinion, the aforementioned financial statements present fairly the financial position of The Robert Wood Johnson Foundation at December 31, 1974 and 1973, 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 31, 1975.

The Robert Wood Johnson Foundation
Statement of Assets,
Liabilities and Foundation Principal
at December 31, 1974 and 1973

	1974	1973
Assets		
Cash	$ 204,929	$ 461,801
Securities (at cost, or market value on dates of gifts) (Notes 1 and 2):		
Johnson & Johnson common stock 9,332,123 shares in 1974, 9,549,975 shares in 1973 (quoted market value $754,735,448 and $1,076,759,681)	267,520,830	273,765,928
Other corporate common stocks (quoted market value $48,290,088 and $52,405,188)	76,699,846	62,593,857
Fixed income securities (quoted market value $164,097,937 and $172,137,415)	176,140,446	175,818,059
Fixed assets (Land, construction in progress and furniture and equipment, net of depreciation)	3,325,344	183,459
	$523,891,395	$512,823,104
Liabilities and Foundation Principal		
Liabilities:		
Unpaid grants (Note 1)	$ 78,218,631	$ 52,397,579
Drafts payable	50,000	451,703
Federal excise tax payable	1,172,019	1,558,171
Total liabilities	79,440,650	54,407,453
Foundation Principal	444,450,745	458,415,651
	$523,891,395	$512,823,104

See notes to financial statements, page 46.

The Robert Wood Johnson Foundation
Statement of Investment Income, Expenses, Grants and Changes in Foundation Principal
for the years ended December 31, 1974 and 1973

	1974	1973
Investment income:		
Dividends	$ 9,394,408	$ 6,945,099
Interest	13,759,991	11,786,688
	23,154,399	18,731,787
Less direct investment expenses and Federal excise tax	1,081,955	901,295
	22,072,444	17,830,492
Expenses:		
Salaries, employee benefits and payroll taxes	1,140,329	860,958
Professional services	378,726	324,750
Rent and leasehold improvements	109,000	124,583
Meeting and travel expenses	170,325	106,896
Other administrative expenses	311,909	232,180
	2,110,289	1,649,367
Income available for grants	19,962,155	16,181,125
Grants	47,791,357	52,953,437
Excess of expenses and grants over investment income	(27,829,202)	(36,772,312)
Additions to Foundation Principal:		
Net capital gains on sales of securities (Note 3)	13,152,335	36,024,009
Less related Federal excise tax	254,142	816,909
	12,898,193	35,207,100
Contributions received:		
Trusts	879,337	546,651
Individuals	86,766	2,363
	13,864,296	35,756,114
Net decrease in Foundation Principal	(13,964,906)	(1,016,198)
Foundation Principal at beginning of year	458,415,651	459,431,849
Foundation Principal at end of year	$444,450,745	$458,415,651

See notes to financial statements, page 46.

1. Summary of significant accounting policies:

   Grants

   Grants are recorded as payables in the year the grant requests are approved by the Board of Trustees. At December 31, 1974, unpaid grants consist of $9,726,079, $25,824,967, and $42,667,585 of grant requests approved in 1972, 1973, and 1974, respectively.

   Interest income

   Interest income is recorded on the cash basis. At December 31, 1974 and 1973, the amounts of unrecorded accrued interest income were approximately $4,660,000 and $3,900,000, respectively.

2. The quoted market values of investments do not necessarily represent the realizable values of such investments.

3. The net capital gains (losses) on sales or exchanges of securities for the years ended December 31, 1974 and 1973 were as follows:

	1974	1973
Johnson & Johnson common stock	$15,091,954	$37,450,638
Other securities, net	(1,939,619)	(1,426,629)
	$13,152,335	$36,024,009

4. The Foundation has a non-contributory insured pension plan covering all eligible employees. Pension expense approximated $112,000 and $78,600 in 1974 and 1973, respectively.

Other corporate common stocks
at December 31, 1974

	Shares	Cost	Quoted market value
AMP Incorporated	6,000	$ 232,893	$ 143,250
American District Telegraph Company	16,000	547,508	264,000
American Home Products Corporation	27,000	1,119,969	897,750
American International Group, Inc.	6,500	401,175	269,750
Arizona Bank	4,600	137,250	64,400
Barnett Banks of Florida, Inc.	4,000	201,562	40,000
Baxter Laboratories, Inc.	15,000	634,677	513,750
Burnup & Sims Inc.	15,000	346,162	45,000
Burroughs Corporation	15,000	1,609,071	1,132,500
Central Telephone & Utilities Corporation	20,000	451,024	330,000
Citicorp	25,000	968,833	709,375
Citizens & Southern Corp.	7,000	180,150	87,500
The Coca-Cola Company	3,500	449,815	185,500
Walt Disney Productions	8,100	579,565	173,138
R. R. Donnelley & Sons Company	15,000	289,278	283,125
The Dow Chemical Company	6,000	308,956	330,000
Dun & Bradstreet Companies, Inc.	8,000	310,280	154,000
Eastman Kodak Company	17,000	2,044,020	1,068,875
Economics Laboratory, Inc.	14,000	528,250	336,000
Emerson Electric Co.	21,000	870,028	514,500
Emery Air Freight Corporation	6,000	327,849	201,000
Engelhard Minerals & Chemicals Corporation	51,000	940,293	905,250
Equitable Bancorporation	4,500	198,775	72,000
Exxon Corporation	6,000	515,189	387,750
Farmers New World Life Insurance Co.	6,000	329,750	267,000
First International Bancshares	4,000	188,930	140,000
Florida Power & Light Company	33,000	892,725	511,500
Ford Motor Company	500,000	27,120,300	16,687,500
Gannett Co., Inc.	15,000	547,846	348,750
General Mills, Inc.	21,000	1,176,628	850,500
General Reinsurance Corporation	2,000	412,400	346,000
The Goodyear Tire & Rubber Company	28,000	397,417	360,500
W. W. Grainger, Inc.	20,000	669,007	347,500
Hercules Incorporated	25,000	864,020	600,000
Hewlett-Packard Company	6,000	517,077	360,750
International Business Machines Corporation	15,000	4,522,404	2,520,000
International Flavors & Fragrances Inc.	15,000	543,770	371,250
International Paper Company	12,000	565,956	429,000

	Shares	Cost	Quoted market value
Kennecott Copper Corporation	15,000	$ 487,123	$ 541,875
Knight-Ridder Newspapers, Inc.	15,000	512,989	217,500
S. S. Kresge Company	37,000	1,304,289	818,625
The Lubrizol Corp.	12,000	527,327	471,000
MGIC Investment Corporation	2,000	144,805	18,750
Marathon Oil Company	18,000	795,207	625,500
Masonite Corporation	25,000	560,215	434,375
Minnesota Mining & Manufacturing Company	10,000	732,745	461,250
Mobil Oil Corporation	28,000	1,757,442	1,008,000
Motorola, Inc.	20,000	1,023,502	682,500
National Starch & Chemical Corporation	10,500	575,068	317,625
A. C. Nielsen Co. (A, nonvoting)	20,000	537,337	200,000
J. C. Penney Company, Inc.	16,000	1,220,008	574,000
PepsiCo, Inc.	14,000	1,042,350	568,750
Phelps Dodge Corporation	15,000	678,049	438,750
Polaroid Corporation	5,000	355,466	93,125
The Procter & Gamble Company	6,000	593,508	489,000
Puritan-Bennett Corporation	4,000	250,025	108,000
Ralston Purina Company	15,000	591,273	558,750
Reynolds and Reynolds Company (A)	38,000	1,140,500	323,000
Roadway Express, Inc.	15,000	467,500	408,750
Schering-Plough Corporation	15,000	1,108,659	787,500
Schlumberger Limited	7,000	662,817	755,125
Sears, Roebuck and Co.	10,000	981,501	482,500
Standard Oil Company (Indiana)	22,000	1,022,333	957,000
Sun Banks of Florida, Inc.	5,000	176,375	37,500
The Superior Oil Company	1,500	284,321	258,000
Tennant Company	10,000	380,750	210,000
Texaco Inc.	53,000	1,816,307	1,106,375
Wal-Mart Stores, Inc.	25,000	432,976	237,500
Wells Fargo & Company	31,000	763,654	403,000
Weyerhaeuser Company	10,000	355,019	273,750
Xerox Corporation	2,200	311,292	113,300
Zions Utah Bancorporation	6,000	166,312	60,750
		$76,699,846	$48,290,088

Fixed income securities
at December 31, 1974

	Face amount	Cost	Quoted market value
U.S. Government obligations:			
Bills due 11-18-75	$ 5,425,000	$ 5,028,643	$ 5,091,200
Bank certificates of deposit:			
Bank of America			
7½% due 2-5-75	2,000,000	2,000,368	1,994,580
Chemical Bank			
9.85% due 4-8-75	3,000,000	3,013,546	3,003,150
10.02% due 6-10-75	5,000,000	5,000,904	5,008,550
9.35% due 10-3-75	5,000,000	5,020,710	5,018,450
Continental Illinois National Bank & Trust Co. of Chicago			
9.05% due 1-20-75	150,000	150,000	149,940
8.90% due 2-18-75	200,000	200,000	199,774
First National Bank of Boston			
9.20% due 3-14-75	5,000,000	5,000,897	4,989,850
First National Bank of Chicago			
9.15% due 4-4-75	5,000,000	5,007,187	4,995,200
9.70% due 5-14-75	5,000,000	5,012,917	5,003,900
Manufacturers Hanover Trust Co.			
12.20% due 1-10-75	2,000,000	2,003,430	2,001,000
9% due 5-1-75	3,000,000	3,001,508	2,996,640
9% due 5-5-75	5,000,000	5,006,468	4,994,450
Morgan Guaranty Trust Co. of New York			
9⅜% due 1-13-75	2,700,000	2,700,000	2,699,325
12% due 3-17-75	5,000,000	5,000,000	5,025,650
12% due 3-28-75	5,000,000	5,000,000	5,029,100
Wells Fargo Bank			
10.05% due 5-14-75	5,000,000	5,002,296	5,001,800
	58,050,000	58,120,231	58,111,359
Other bonds and notes:			
Bankamerica Corp.			
6⅝% notes due 2-1-80	3,000,000	2,986,800	2,700,000
Beneficial Corp.			
6¾% debentures due 7-15-79	2,000,000	2,000,000	1,835,000
7½% debentures due 7-15-02	3,000,000	2,982,000	2,238,750
Chemical New York Corp.			
6⅝% notes due 4-15-80	3,000,000	2,982,900	2,640,000
Chesapeake & Potomac Telephone Co. of Va.			
6½% notes due 6-1-78	3,000,000	3,000,000	2,868,750
7¼% debentures due 6-1-12	2,000,000	1,977,500	1,590,000

	Face amount	Cost	Quoted market value
Commercial Credit Co.			
6⅞% notes due 7-15-79	$ 3,000,000	$ 2,985,000	$ 2,550,000
Consolidated Natural Gas Co.			
7⅝% debentures due 5-1-97	3,000,000	3,036,930	2,580,000
Consumers Power Co.			
7½% first mortgage bonds due 6-1-02	3,000,000	3,018,750	2,096,250
Dow Chemical Co.			
7.40% debentures due 7-15-02	2,000,000	2,000,000	1,590,000
Duke Power Co.			
6⅝% promissory notes due 11-1-75	5,000,000	5,000,000	5,000,000
Export Import Bank of the U.S.			
8.35% debentures, series 1978-B due 8-28-78	2,000,000	2,000,000	2,040,000
Farmers Home Administration			
6.45% insured notes, series K due 6-30-77	4,995,380	4,977,896	4,776,833
6.55% insured notes, series M due 12-29-77	2,002,756	2,002,756	1,912,632
Federal Home Loan Banks			
7.80% consolidated bonds, series C1976 due 8-25-76	3,000,000	3,000,000	2,992,500
9.55% consolidated bonds, series I1976 due 8-25-76	1,000,000	1,000,000	1,023,750
9⅜% consolidated bonds, series C1978 due 2-27-78	3,000,000	3,016,875	3,131,250
Federal Home Loan Mortgage Corp.			
7.15% guaranteed mortgage bonds due 5-26-82 to 97	3,000,000	3,013,125	2,583,750
Federal National Mortgage Association			
7.55% debentures, series SM1977H due 12-12-77	2,000,000	2,000,000	1,992,500
7.05% debentures, series SM1992B due 6-10-92	5,000,000	5,000,094	4,356,250
GTE Sylvania, Inc.			
Demand notes	42,000	42,000	42,000
General Electric Credit Corp.			
6⅝% notes due 8-15-77	5,000,000	5,000,000	4,625,000
General Motors Acceptance Corp.			
Demand notes	74,000	74,000	74,000
General Telephone Co. of Florida			
7½% first mortgage bonds due 8-1-02	1,000,000	990,570	710,000

	Face amount	Cost	Quoted market value
Household Finance Corp.			
7½ % debentures, series IF due 8-1-95	$ 3,000,000	$ 3,000,000	$ 2,475,000
International Harvester Credit Corp.			
Demand notes	49,000	49,000	49,000
Michigan Consolidated Gas Co.			
7⅝ % first mortgage bonds due 7-1-97	2,000,000	1,978,125	1,562,500
J.P. Morgan & Co. Incorporated			
9¾ % promissory note due 4-15-75	5,000,000	4,746,770	4,859,167
Mountain States Telephone & Telegraph Co.			
7¾ % debentures due 6-1-13	2,000,000	2,000,000	1,700,000
Northern Illinois Gas Co.			
7⅝ % first mortgage bonds due 7-1-97	2,000,000	2,005,540	1,540,000
Northwestern Bell Telephone Co.			
7½ % debentures due 4-1-05	3,000,000	3,042,500	2,460,000
Pacific Gas & Electric Co.			
7½ % first and refunding mortgage bonds, series YY due 6-1-04	3,000,000	3,000,000	2,430,000
Southern Bell Telephone & Telegraph Co.			
6½ % notes due 7-15-79	2,000,000	1,987,500	1,860,000
7⅜ % debentures due 7-15-10	3,000,000	2,952,500	2,433,750
Southern California Edison Co.			
7⅜ % first and refunding mortgage bonds, series BB due 8-15-97	1,000,000	997,170	775,000
Southwestern Bell Telephone Co.			
6½ % notes due 5-1-79	3,000,000	2,976,250	2,820,000
7⅜ % debentures due 5-1-12	3,000,000	2,990,400	2,445,000
Tennessee Valley Authority			
7.35% power bonds, series C due 7-1-97	4,000,000	4,000,000	3,440,000
Textron Inc.			
7½ % sinking fund debentures due 7-15-97	2,000,000	2,000,000	1,560,000
Toledo Edison Co.			
7½ % first mortgage bonds due 8-1-02	2,000,000	1,995,000	1,490,000
Twelve Federal Land Banks			
9.20% consolidated bonds, series F-1976 due 1-20-76	5,000,000	4,978,125	5,050,000
6.80% consolidated loan bonds due 10-23-79	4,000,000	4,063,750	3,855,000
	113,163,136	112,849,826	100,753,632
	176,638,136	175,998,700	163,956,191
Purchased interest	141,746	141,746	141,746
	$176,779,882	$176,140,446	$164,097,937

Summary of Grants
for the year ended December 31, 1974

Adelphi University
Garden City, New York

Study of the role of nurses in primary care

Alderson-Broaddus College
Philippi, West Virginia

Physicians assistants program in primary care
[$693,000 authorized in 1973]

American Arbitration Association
New York, New York

Program to improve the management of ambulatory care institutions

---

American Association for Comprehensive Health Planning
Alexandria, Virginia

Technical assistance for health planning agencies
[$200,000 authorized in 1973]

American Association of Community and Junior Colleges
Washington, D.C.

Preparation and publication of a study report on health professions education

---

American College of Surgeons and American Surgical Association

Joint study of surgical services in the United States

Johns Hopkins University, School of Medicine
Baltimore, Maryland
[$66,747 authorized in 1973]

University of Michigan Medical School
Ann Arbor, Michigan
[$86,400 authorized in 1973]

American Fund for Dental Education
Chicago, Illinois

Administration of the Foundation's dental student aid program
[$40,000 authorized in 1972]

Grants awarded in 1974 appear in green. Those awarded in prior years appear in black. The original amount of a grant awarded in prior years appears in brackets following the grant description.

Unpaid grants January 1, 1974	1974 grants authorized	1974 payments	Unpaid grants December 31, 1974
$	$ 290,299	$ 23,037	$ 267,262
475,135		80,831	394,304
	167,000	20,875	146,125
100,000		25,000	75,000
	41,200	41,200	
66,747		66,747	
43,200		43,200	
20,000			20,000

American Fund for Dental Education
(continued from page 52)

Administration of the Foundation's program to train dentists in the care of the handicapped
[$150,000 authorized in 1973]

American Medical Association Education and Research Foundation
Chicago, Illinois

Planning for professional certification of new health practitioners

Workshop program on regional emergency medical response systems

American Society of Contemporary Medicine and Surgery
Chicago, Illinois

Development of a nationwide telephone consultation service for physicians

Appalachian Regional Hospitals, Inc.
Hazard, Kentucky

Outreach service for the care of mothers, infants, and young children

Association of American Medical Colleges
Washington, D.C.

Administration of the Foundation's medical student aid program
[$40,000 authorized in 1972]

Program to strengthen the management capabilities of academic medical centers

Support of a symposium on primary care

Association of Physician Assistant Programs
Washington, D.C.

Program with the American Academy of Physicians Assistants to foster training of new health practitioners
[$123,473 authorized in 1973]

Bank Street College of Education
New York, New York

Planning a child health care program with the Martin Luther King Health Center

Baylor College of Medicine
Houston, Texas

Preparation of physicians in primary care
[$240,000 authorized in 1973]

Bedford-Stuyvesant Restoration Corporation
Brooklyn, New York

Planning for a primary care center

Unpaid grants January 1, 1974	1974 grants authorized	1974 payments	Unpaid grants December 31, 1974
$ 100,000	$	$ 16,871	$ 83,129
	51,365	26,925	24,440
	59,700	59,700	
	300,000	125,000	175,000
	623,619	129,813	493,806
20,000	56,880	46,895	29,985
	540,000	49,030	490,970
	24,000	24,000	
63,473			63,473
	24,238	24,238	
160,000			160,000
	18,530	18,530	

Beth Israel Hospital
Boston, Massachusetts

Development of a research capability in ambulatory care

Boston City Hospital
Boston, Massachusetts

Program to prepare physicians and nurses for career service in general medical care

Boy Scouts of America
North Brunswick, New Jersey

National program of health education
[$144,000 authorized in 1973]

The Brookings Institution
Washington, D.C.

Study of the impact of government financing programs on health care
[$119,200 authorized in 1972]

Town of Brookline, Massachusetts, Public Schools
Brookline, Massachusetts

Health program for infants and preschool children
[$400,000 authorized in 1972]

University of California, Berkeley
Berkeley, California

Research on selection criteria for future physicians
[$227,000 authorized in 1972]

University of California, Davis, School of Medicine
Davis, California

Program for the preparation and placement of rural nurse practitioners
[$1,178,000 authorized in 1973]

Rural health care planning

University of California, San Francisco, School of Medicine
San Francisco, California

Establishment of a health policy center
[$1,200,000 authorized in 1973]

Program to prepare physicians and nurses in primary care

Center for Research in Ambulatory Health Care Administration
Denver, Colorado

Program to train managers of ambulatory care centers

Unpaid grants January 1, 1974	1974 grants authorized	1974 payments	Unpaid grants December 31, 1974
$	$ 512,337	$ 44,779	$ 467,558
	395,451	48,431	347,020
72,000			72,000
59,600		51,735	7,865
54,806	642,386	83,336	613,856
124,403		31,008	93,395
790,140			790,140
	13,616	13,616	
800,000		199,960	600,040
	500,067	54,091	445,976
	491,191	120,281	370,910

University of Chicago
Chicago, Illinois

Development of a national index to measure access to physician care

National study of health care financing

Children's Hospital
Washington, D.C.

Development of a child care program

Children's Hospital Medical Center
Boston, Massachusetts

Training a clinical faculty in child development

Children's Television Workshop
New York, New York

Planning and production of a national television program on health
[$1,700,000 authorized in 1973]

Citizens Conference on State Legislatures
Kansas City, Missouri

Program to strengthen the role of state legislatures in health
[$1,996,000 authorized in 1973]

La Clinica del Pueblo de Rio Arriba
Tierra Amarilla, New Mexico

Development of a mother and infant care training program

Clinical Scholars Program

National program to prepare young physicians for leadership roles in medical care
[$5,900,000 authorized in 1972 and $748,381 authorized in 1973]
(See Schedule A, page 86)

University of Colorado, School of Medicine
Denver, Colorado

Center for the Prevention and Treatment of Child Abuse and Neglect
[$588,000 authorized in 1972]

Project to provide rural doctors with student assistance
[$519,000 authorized in 1973]

Planning for a new medical curriculum to prepare non-M.D. primary care practitioners

---

Unpaid grants January 1, 1974	1974 grants authorized	1974 payments	Unpaid grants December 31, 1974
$	$ 125,673	$ 62,836	$ 62,837
	18,530	18,530	
	135,628	33,907	101,721
	257,007	23,234	233,773
1,500,000		750,000	750,000
1,411,150		812,150	599,000
	134,765	54,435	80,330
6,143,534	4,405,641	770,160	9,779,015
408,588		51,381	357,207
357,600			357,600
	155,400	17,050	138,350

Columbia University
New York, New York

Public policy program in health services and manpower
[$222,000 authorized in 1973]

Feasibility study of medical manpower planning

Columbia University, Center for Community Health Systems
New York, New York

Preparation of a manual on hospital-sponsored primary care group practices

---

Columbia University, College of Physicians and Surgeons
New York, New York

Development of child care services

Commission on Private Philanthropy and Public Needs
Washington, D.C.

Study of the role of private philanthropy in the United States

---

Cornell University Medical College
New York, New York

Planning for ambulatory care
[$499,000 authorized in 1973]

Study of doctor-patient communications

Cottonwood Health Group, Inc.
Tekamah, Nebraska

Development of a community health center
[$209,000 authorized in 1973]

Council on Foundations
New York, New York

Service and educational programs
[$60,000 authorized in 1972]

Dartmouth College, Medical School
Hanover, New Hampshire

Development of a primary care service and training programs

Dental Training Program

Grants to dental schools to train dentists in the care of the handicapped
[$4,700,000 authorized in 1973]
(See Schedule B, page 87)

Unpaid grants January 1, 1974	1974 grants authorized	1974 payments	Unpaid grants December 31, 1974
$ 148,000	$	$	$ 148,000
	20,750	20,750	
	36,406	36,406	
	500,000	62,041	437,959
	50,000	50,000	
160,000			160,000
	154,767	22,126	132,641
87,556			87,556
40,000		20,000	20,000
	1,154,685	59,120	1,095,565
4,700,000		317,052	4,382,948

Charles R. Drew Postgraduate Medical School
Los Angeles, California

Planning for a primary care training and service program

Duke University, School of Medicine
Durham, North Carolina

Research and training in primary care community practice
[$1,134,375 authorized in 1972]

East Kentucky Health Services Center, Inc.
Hindman, Kentucky

Development of a nonprofit rural group practice
[$400,000 authorized in 1973]

Eastern Virginia Medical School
Norfolk, Virginia

Grant for scholarships and loans

Educational Testing Service
Princeton, New Jersey

Planning and development of a program to evaluate the Foundation's dental training program for the care of the handicapped

---

Emergency Medical Response Program

Grants to communities developing regional systems
[$15,000,000 authorized in 1973]
(See Schedule C, page 88)

Evanston Medical Consumers
Evanston, Illinois

Development of a nonprofit group practice
[$188,000 authorized in 1973]

University of Florida, College of Medicine
Gainesville, Florida

Development of primary care health services
[$183,000 authorized in 1973]

Frontier Nursing Service
Wendover, Kentucky

Publication of a primary care handbook for nurse practitioners

---

Unpaid grants January 1, 1974	1974 grants authorized	1974 payments	Unpaid grants December 31, 1974
$	$ 164,057	$ 27,343	$ 136,714
768,896		281,679	487,217
200,000		175,000	25,000
	25,000	25,000	
	300,530	38,153	262,377
15,000,000		8,189,579	6,810,421
100,000			100,000
151,800		48,126	103,674
	10,500	10,500	

Genesee Hospital
Rochester, New York

Expansion of an ambulatory care program
[$187,000 authorized in 1973]

George Washington University
Washington, D.C.

Seminar program for government health staff professionals

George Washington University, School of Medicine
Washington, D.C.

Program in primary care
[$600,000 authorized in 1973]

Georgetown University Graduate School
Washington, D.C.

Evaluation of programs to strengthen the role of state legislatures in health
[$233,300 authorized in 1973]

Planning and development of a health policy center

Georgetown University, School of Medicine
Washington, D.C.

Planning and program to improve methods for evaluating the quality of health care services
[$626,119 authorized in 1973]

Development of a primary care prepaid group practice program

Glenville Health Association
Cleveland, Ohio

Development of a nonprofit group practice
[$400,000 authorized in 1973]

The Greater Hartford Process
Hartford, Connecticut

Development of primary care programs

Group Health Foundation
Washington, D.C.

Program with the University of Pennsylvania to prepare managers for prepaid group practices

---

Unpaid grants January 1, 1974	1974 grants authorized	1974 payments	Unpaid grants December 31, 1974
$ 110,291	$	$	$ 110,291
	498,178	76,500	421,678
400,000			400,000
160,335			160,335
	1,328,734	49,922	1,278,812
374,785			374,785
	135,000	135,000	
400,000		150,000	250,000
	247,267	41,211	206,056
	48,000	15,000	33,000

Harvard Community Health Plan, Inc.
Boston, Massachusetts

Development of primary care prepaid group practice program
[$446,106 authorized in 1972]

Harvard University
Cambridge, Massachusetts

Expansion of a preprofessional health career program

Harvard University, Medical School
Boston, Massachusetts

Research in selection criteria for training future primary care doctors
[$167,250 authorized in 1972]

Program to train physicians and nurses for primary medical care
[$337,644 authorized in 1973]

Harvard University, School of Public Health
Cambridge, Massachusetts

Studies of the effectiveness of selected medical procedures
[$750,000 authorized in 1973]

Harvard University, School of Public Health,
Graduate School of Education, and
School of Government
Cambridge, Massachusetts

National study of child health and ambulatory health care standards
[$500,000 authorized in 1973]

Harvard University, Department of Economics
Cambridge, Massachusetts

Health economics training program
[$423,000 authorized in 1973]

Harvard University, Center for Community Health and Medical Care
Boston, Massachusetts

Program in health services development
[$375,000 authorized in 1973]

Health Care Management Systems, Inc.
Tooele, Utah

Development of information systems for ambulatory care

Preparation of a report on computer use in ambulatory care

Unpaid grants January 1, 1974	1974 grants authorized	1974 payments	Unpaid grants December 31, 1974
$ 49,430	$ 450,000	$ 473,970	$ 25,460
	24,300	24,300	
111,500		30,000	81,500
337,644	821,004	88,051	1,070,597
500,000			500,000
450,000		142,287	307,713
288,600			288,600
375,000		93,731	281,269
	396,152	40,416	355,736
	4,000	4,000	

Health and Education Council, Inc.
Baltimore, Maryland
Development of an ambulatory care system

Health and Hospitals Governing Commission of Cook County, Illinois
Chicago, Illinois
Planning and reorganizing the ambulatory care program

University of Illinois, Abraham Lincoln School of Medicine
Chicago, Illinois
Expansion of Urban Preceptorship Program
[$576,390 authorized in 1972]

Indiana University Foundation
Bloomington, Indiana
Planning a new health practitioner training program for Gary, Indiana

Institute of Society, Ethics and the Life Sciences
Hastings-on-the-Hudson, New York
Study of the role of ethical values in health
[$293,000 authorized in 1973]

Johns Hopkins University
Baltimore, Maryland
School of health services training program
[$3,000,000 authorized in 1973]

Johns Hopkins University, Center for Health Services Research and Development
Baltimore, Maryland
Evaluation of the Foundation's perinatal program

Johns Hopkins University, School of Medicine
Baltimore, Maryland
Program to train physicians in emergency medicine

University of Kentucky, College of Dentistry
Lexington, Kentucky
Training and evaluation of dental hygienists in primary dental care

Maine Medical Center
Portland, Maine
Community service and teaching program in primary care
[$359,000 authorized in 1973]

Unpaid grants January 1, 1974	1974 grants authorized	1974 payments	Unpaid grants December 31, 1974
$	$ 261,503	$ 22,820	$ 238,683
	14,000	14,000	
440,000			440,000
	107,185	35,729	71,456
199,000		73,079	125,921
2,500,000		947,310	1,552,690
	2,013,220	24,000	1,989,220
	754,272	53,325	700,947
	269,795	66,022	203,773
205,000		29,350	175,650

The Martinez Health Center, Inc.
Martinez, California

Development of primary care prepaid group practice program
[$350,000 authorized in 1972]

Massachusetts Institute of Technology
Cambridge, Massachusetts

Studies of the application of technology to primary care

Massachusetts Institute of Technology, Alfred P. Sloan School of Management
Cambridge, Massachusetts

Program to improve primary care team skills

The Matheny School*
Peapack, New Jersey

Purchase of equipment

The Matthew Thornton Health Plan, Inc.
Nashua, New Hampshire

Development of a nonprofit group practice
[$356,000 authorized in 1973]

Meharry Medical College
Nashville, Tennessee

Improvement of teaching and service programs in primary care
[$5,000,000 authorized in 1972]

University of Michigan, School of Public Health
Ann Arbor, Michigan

Program on health manpower development
[$375,000 authorized in 1973]

Monograph on access to primary care services

Middlesex County College Foundation, Inc.*
Edison, New Jersey

Expansion of a program in health sciences
[$51,943 authorized in 1972]

Refresher training to return inactive RN's to nursing service

Support for the medical laboratory technology program

Unpaid grants January 1, 1974	1974 grants authorized	1974 payments	Unpaid grants December 31, 1974
$ 100,000	$	$ 100,000	$
	24,882	24,882	
	440,449	51,648	388,801
	5,000	5,000	
156,000		102,000	54,000
3,173,223		1,323,223	1,850,000
255,747		31,101	224,646
	12,878	12,878	
29,950		13,450	16,500
	7,288	7,288	
	4,780	4,780	

Middlesex General Hospital*
New Brunswick, New Jersey

Land acquisition and purchase of equipment

Planning project for the establishment of a hospital-based primary care group pract

---

University of Missouri, Kansas City, School of Medicine
Kansas City, Missouri

Program to prepare physicians and nurses for careers in general medical care

---

Montefiore Hospital and Medical Center
Bronx, New York

Training physicians and other professionals in team practice
[$700,000 authorized in 1973]

Montgomery County, Maryland, Medical Care Foundation, Inc.
Wheaton, Maryland

Program to improve access to physician care

Morehead Clinic
Morehead, Kentucky

Development of primary care satellite clinics in northeast Kentucky

---

Mount Sinai School of Medicine
New York, New York

Primary care services for children and youth
[$600,000 authorized in 1973]

National Academy of Sciences, Institute of Medicine
Washington, D.C.

Fellowships in health policy program
[$710,000 authorized in 1973]

National Academy of Sciences, National Research Council
Washington, D.C.

Administration of the Foundation's regional emergency medical response program
[$300,000 authorized in 1973]

National Board of Medical Examiners
Philadelphia, Pennsylvania

Development of a national examination for qualifying physicians assistants
[$139,950 authorized in 1972]

Unpaid grants January 1, 1974	1974 grants authorized	1974 payments	Unpaid grants December 31, 1974
$	$ 320,000	$ 320,000	$
	349,609	205,583	144,026
	901,670		901,670
400,000		81,410	318,590
	121,327	71,127	50,200
	245,860	29,845	216,015
357,000		150,000	207,000
602,000		147,667	454,333
100,000			100,000
83,300		27,128	56,172

National Bureau of Economic Research
New York, New York

Research and training program in health economics
[$210,000 authorized in 1972]

National 4-H Club Foundation of America, Inc.
Washington, D.C.

Planning a national program in health

National Health Council
New York, New York

Program to strengthen organizations and agencies working in health
[$250,000 authorized in 1973]

National Medical Fellowships
New York, New York

Scholarships for minority medical students
[$1,000,000 authorized in 1973]

National Planning Association
Washington, D.C.

Study of the impact of student aid programs
[$206,728 authorized in 1973]

Administration of the Foundation's community hospital ambulatory care program

Analysis of health policy issues

University of Nebraska, Medical Center
Omaha, Nebraska

Planning primary care service programs
[$503,000 authorized in 1973]

University of Nevada
Reno, Nevada

Program to train health professions students in primary care
[$1,051,000 authorized in 1972]

College of Medicine and Dentistry of New Jersey
Newark, New Jersey

Planning for training and service programs
[$493,000 authorized in 1973]

Program to strengthen preprofessional training for minority-group students

Unpaid grants January 1, 1974	1974 grants authorized	1974 payments	Unpaid grants December 31, 1974
$ 150,000	$	$ 16,600	$ 133,400
	80,750		80,750
65,600			65,600
500,000		500,000	
121,439			121,439
	414,833	414,833	
	238,095	116,144	121,951
373,680			373,680
666,582		324,511	342,071
340,505		25,984	314,521
	55,000	55,000	

College of Medicine and Dentistry of New Jersey, Rutgers Medical School
Piscataway, New Jersey

Planning a family physician training program for New Jersey

University of New Mexico, School of Medicine
Albuquerque, New Mexico

Planning for the development of a training program for family health practitioners

University of North Carolina
Chapel Hill, North Carolina

National study of primary care health centers

University of Pennsylvania
Philadelphia, Pennsylvania

Study of economics and financing of emergency medical systems

Study of prepaid group practice enrollment plans

University of Pennsylvania, School of Dental Medicine
Philadelphia, Pennsylvania

Planning for the development of a preventive dental care program for school children

University of Pennsylvania, Wharton School
Philadelphia, Pennsylvania

Program to prepare managers for prepaid group practices

Perinatal Program[1]

Grants to universities developing regional high risk pregnancy networks

University of Pittsburgh, School of Medicine
Pittsburgh, Pennsylvania

Expansion of a child care program

Princeton Area United Community Fund
Princeton, New Jersey

Campaign support

Princeton University
Princeton, New Jersey

Analytical history of the development of U.S. health policy

Unpaid grants January 1, 1974	1974 grants authorized	1974 payments	Unpaid grants December 31, 1974
$	$ 147,597	$	$ 147,597
	24,982	24,982	
	254,288		254,288
	188,388	46,640	141,748
	24,733	24,733	
	69,085	69,085	
	678,033	55,683	622,350
	17,600,000		17,600,000
	475,809		475,809
	20,000	20,000	
	39,239	39,239	

Public Technology, Inc.
Washington, D.C.

Emergency medical services technical assistance program

Radcliffe College
Cambridge, Massachusetts

Preparation and placement of women in community health careers
[$318,000 authorized in 1973]

The Rand Corporation
Santa Monica, California

Evaluation of regional emergency medical response systems
[$462,650 authorized in 1973]

University of Rochester
Rochester, New York

Program to train physicians and nurses for general medical care
[$1,395,000 authorized in 1973]

Roxbury Dental and Medical Group, Inc.
Roxbury, Massachusetts

Expansion of a nonprofit group practice in inner-city Boston

Rural Health Care Association
Denver, Colorado

Strengthening rural primary care practice in
Colorado and adjacent states

Rush-Presbyterian-St. Luke's Medical Center
Chicago, Illinois

System of education and service in ambulatory care
[$434,000 authorized in 1973]

St. Joseph Hospital
Albuquerque, New Mexico

Development of a rural health clinic network
[$213,000 authorized in 1973]

St. Peter's General Hospital*
New Brunswick, New Jersey

Purchase of equipment

Unpaid grants January 1, 1974	1974 grants authorized	1974 payments	Unpaid grants December 31, 1974
$	$ 673,967	$ 187,350	$ 486,617
161,000		83,522	77,478
248,952			248,952
918,239			918,239
	224,840	21,100	203,740
	462,400	131,300	331,100
339,055		109,036	230,019
168,750		48,424	120,326
	250,000	250,000	

St. Peter's General Hospital School of Nursing*
New Brunswick, New Jersey
Nursing scholarships

St. Vincent de Paul Society*
Highland Park, New Jersey
Program of assistance to the indigent

Salvation Army*
New Brunswick, New Jersey
Program of assistance to the indigent

University of Southern California, School of Medicine
Los Angeles, California
Study of the role of medical specialists in primary care

Student American Medical Association Foundation
Rolling Meadows, Illinois
Field service in community health for health science students
[$250,000 authorized in 1973]

Student National Medical Association
Washington, D.C.
National medical preceptorship program
[$83,000 authorized in 1973]

Sun Valley Forum on National Health, Inc.
Sun Valley, Idaho
Program of symposia on health policy issues

University of Tennessee, College of Medicine
Memphis, Tennessee
Development of a primary care network

University of Texas Medical Branch at Galveston
Galveston, Texas
Primary care services for school-age children

Thomas Jefferson University
Philadelphia, Pennsylvania
Planning for ambulatory care
[$650,000 authorized in 1973]

Unpaid grants January 1, 1974	1974 grants authorized	1974 payments	Unpaid grants December 31, 1974
$	$ 24,000	$ 24,000	$
	10,000	10,000	
	10,000	10,000	
	213,090	69,553	143,537
100,000			100,000
40,000	125,000	102,500	62,500
	25,000	25,000	
	801,504	66,792	734,712
	824,796	91,228	733,568
458,000		67,447	390,553

Tulane University
New Orleans, Louisiana

Program to increase minority enrollment in medical schools

Tuskegee Institute
Tuskegee, Alabama

Development of a primary care health service in rural Alabama

---

United Community Services of Central Jersey, Inc.*
New Brunswick, New Jersey

Campaign support

Upper Connecticut Valley Hospital Association
Colebrook, New Hampshire

Development of a hospital-based primary care group practice

Utah Valley Hospital
Provo, Utah

Network of rural health clinics
[$344,840 authorized in 1972]

University of Vermont, College of Medicine
Burlington, Vermont

Development of an electronic system for a unitary patient record
[$600,000 authorized in 1972]

University of Virginia, School of Medicine
Charlottesville, Virginia

Development of a primary care program

Washington University, School of Medicine
St. Louis, Missouri

Establishment of an ambulatory care teaching practice
[$600,000 authorized in 1973]

University of Wisconsin
Madison, Wisconsin

Research and training in the economics and sociology of health care services
[$486,000 authorized in 1973]

Study of new health practitioners in ambulatory care

Unpaid grants January 1, 1974	1974 grants authorized	1974 payments	Unpaid grants December 31, 1974
$	$ 618,492	$	$ 618,492
	436,045	119,500	316,545
	115,000	115,000	
	234,638	25,100	209,538
173,490		71,764	101,726
260,386			260,386
	312,743	34,286	278,457
400,000		50,000	350,000
329,900			329,900
	217,760	35,561	182,199

Yale University, School of Medicine
New Haven, Connecticut

Research on the structure and quality of primary pediatric care
[$376,000 authorized in 1973]

Refunds
Cancellations

**Local projects in the New Brunswick, New Jersey area.*
[1] *A listing of grant recipients under this program will appear in the 1975 Report.*

Unpaid grants January 1, 1974	1974 grants authorized	1974 payments	Unpaid grants December 31, 1974
$ 296,568	$	$ 10,009	$ 286,559
$52,397,579	48,097,678	22,276,626	$78,218,631
	132,851	132,851	
	173,470	173,470	
	$47,791,357	$21,970,305	

Schedule A—Clinical Scholars Program

University of California, Los Angeles, School of Medicine	$ 856,103
Columbia University, College of Physicians and Surgeons	829,343
George Washington University, School of Medicine	860,670
University of Washington, School of Medicine, Seattle	798,230
Educational development funds	770,647
Administrative costs	290,648
	$4,405,641

Schedule B—Dental Training Program

University of Alabama, School of Dentistry, Birmingham	$ 432,651
University of California, Los Angeles, School of Dentistry	435,351
Columbia University School of Dental and Oral Surgery	357,842
University of Kentucky, College of Dentistry	420,746
University of Maryland, School of Dentistry	466,992
University of Michigan, School of Dentistry	394,481
University of Minnesota, School of Dentistry	395,472
University of Nebraska, School of Dentistry	466,930
New York University, College of Dentistry, The Brookdale, Long Island Dental Center	415,940
University of Tennessee, College of Dentistry	469,876
University of Washington, School of Dentistry, Seattle	441,509
Cancellation of balance of appropriation	2,210
	$4,700,000

Schedule C—Emergency Medical Response Program

Metropolitan Emergency Medical Services, Inc., Atlanta, Georgia	$ 399,421
The City of Hermiston, Oregon	61,616
The City of Victoria, Texas	184,605
Health Systems Management, Inc., Memphis, Tennessee	383,423
Hennepin County Board of Commissioners, Minneapolis, Minnesota	378,254
Hunterdon County Board of Chosen Freeholders, Flemington, New Jersey	319,453
Idaho Department of Environmental and Community Services, Boise, Idaho	399,851
King County Board of Commissioners, Seattle, Washington	362,000
Kitsap County Board of Commissioners, Port Orchard, Washington	386,520
Lebanon County Civil Defense, Lebanon, Pennsylvania	197,800
Louisiana Hospital Association Research and Education Foundation, New Orleans, Louisiana	318,886
Marion County General Hospital, Indianapolis, Indiana	397,312
The Metropolitan Health Planning Corporation, Cleveland, Ohio	398,580
Mid-America Regional Council, Kansas City, Missouri	301,190
Missoula County Government, Missoula, Montana	389,720
Mobile County Emergency Medical Services Council, Mobile, Alabama	264,498
The Navajo Health Authority, Window Rock, Arizona	388,577
Nebraska State Health Department, Lincoln, Nebraska	321,504
New Jersey State Department of Health, Trenton, New Jersey	399,340
New Mexico State Health Agency, Santa Fe, New Mexico	399,975
The North Carolina Memorial Hospital, Chapel Hill, North Carolina	391,205
Northeastern Wisconsin Health Planning Council, Inc., Green Bay, Wisconsin	361,279
Northern California Emergency Medical Care Council, Redding, California	398,366

The Pee Dee (Region H) Council of Governments, Troy, North Carolina	$ 244,090
Philadelphia Health Management Corporation, Philadelphia, Pennsylvania	390,248
Polk County Board of Supervisors, Des Moines, Iowa	387,250
Presbyterian Medical Services, Santa Fe, New Mexico	361,443
Department of Health of Puerto Rico, Santurce, Puerto Rico	318,000
Region VII Comprehensive Health Planning, Inc., Middleboro, Massachusetts	304,181
Saint Francis Hospital, Peoria, Illinois	254,870
San Bernardino County Board of Supervisors, California	399,643
San Francisco, Department of Public Health, California	338,330
Municipality of San Juan, Puerto Rico	212,640
Comprehensive Health Planning Council of San Mateo County, California	313,200
Santa Clara County, Office of Emergency Services, California	357,715
Southern West Virginia Regional Health Council, Inc., Bluefield, West Virginia	399,790
County of Suffolk, New York (Hauppauge)	366,711
Tallahassee Memorial Hospital, Florida	352,347
Tri-County Emergency Medical Services Council, East Lansing, Michigan	306,366
University of Utah, Salt Lake City, Utah	340,432
University of Virginia, Charlottesville, Virginia	322,626
West Central Wisconsin Health Planning Council, Inc., Menomonie, Wisconsin	364,668
Wyoming Hospital Research and Educational Foundation, Cheyenne, Wyoming	328,845
Yale-New Haven Hospital	361,970
Cancellation of balance of appropriation	171,260
	$15,000,000

We were saddened by the sudden death on May 17, 1974 of Paige D. L'Hommedieu, a long-time member of the Board of Trustees. During Mr. L'Hommedieu's 20 years of service, his interest in the Trustees' work, his attention to detail, and his thoughtful focus on the problems being attacked made him a vital contributor to the mission of the Foundation. During the important transition of the Foundation to a major national philanthropy, he made invaluable contributions to the design and scope of its programs. His presence and counsel will be missed.

In July, 1974, George H. Murphy of Westfield, New Jersey, was elected to the Board of Trustees. Mr. Murphy has been prominent in New Jersey business circles for many years, and retired in 1975 as Vice President of Corporate Development for Textron, Inc.

There were a number of additions to the professional staff during 1974. Frank Karel, III, joined the Foundation as Director of Information Services. Mr. Karel received his B.S. degree in journalism from the University of Florida. He has held public information positions at the Johns Hopkins Medical Institutions, the Division of Regional Medical Programs at the National Institutes of Health, and with the Commonwealth Fund. Prior to joining the Foundation, he was associate director for cancer communications for the National Cancer Institute.

Linda Aiken and Calvin Bland joined the staff as program officers. Dr. Aiken received her doctorate in sociology from the University of Texas and her master's degree in nursing from the University of Florida. Prior to joining the Foundation, she was a research associate in the Department of Sociology at the University of Wisconsin. Mr. Bland received his master's degree from the Columbia University School of Public Health, after completing a residency at the Pennsylvania Hospital in Philadelphia. He did his undergraduate work at the Wharton School of the University of Pennsylvania, and has previously worked in several Philadelphia health care institutions.

John M. Thoens joined the Foundation staff as an administrative assistant to the Treasurer. He received his B.S. degree in psychology and a B.A. degree in accounting from Rutgers University. Prior to serving as Captain in the United States Marine Corps in Vietnam, Mr. Thoens was employed by Occidental Petroleum Corporation, New Jersey, and Marlboro State Hospital, New Jersey.

Three senior professionals are working with the Foundation this

year to further the development of new program areas. They devote a substantial amount of their time to affairs of the Foundation, while retaining affiliations with other institutions where they are based.

Irwin R. Merkatz, M.D., is a senior consultant assisting the Foundation in its program to develop regional networks for perinatal care. Dr. Merkatz is professor of obstetrics and gynecology at Case Western Reserve School of Medicine and director of perinatology and obstetrics at University Hospitals in Cleveland, Ohio.

James A. Block, M.D., and Marshall V. Rozzi are assisting the National Planning Association in Washington, D.C., and the Foundation in the program to develop community hospital-medical staff sponsored primary care group practices. Dr. Block and Mr. Rozzi were responsible for the development of the ambulatory care services program at the Genesee Hospital in Rochester, New York.

Two members of the professional staff who assisted in the Foundation's transition to a national philanthropy left during 1974. Stuart Carothers, who joined the Foundation as Secretary in 1972, left to assume a new position with the Mary Institute and the St. Louis Country Day School, two independent secondary schools in St. Louis, Missouri. Carol Richards, one of the Foundation's first program officers, moved to Los Angeles, California. She will continue to serve the Foundation as a consultant.

During 1974, the Board of Trustees met six times to review proposals and to appropriate funds for the implementation of new programs. In addition, the Policy Committee, the Finance Committee, and the Building Committee met as required during the year.

Olga Ferretti
Assistant Secretary

Application for grants

The Robert Wood Johnson Foundation is a private philanthropy interested in improving health in the United States. It is concentrating its resources on a few well defined needs in health: the need to improve access to health care; the need to improve the performance of health care services in order to ensure quality care; and the need to develop mechanisms for the objective analysis of public policies in health.

The Foundation will encourage and support only those projects and programs which show promise of having significant regional and national impact, with one exception, which will be local projects in the New Brunswick, New Jersey area, where the Foundation was established.

The initial policy guidelines that have been established by the Foundation's board of trustees will normally preclude support for the following types of activities:

1. Endowment, construction, equipment, or general operating expenses.
2. Biomedical research.
3. International activities or programs and institutions in other countries.
4. Direct support to individuals.

Also, the Foundation will not be able to support programs concerned with a particular disease or with broad public health problems such as drug abuse, alcoholism, mental health, population dynamics, the effects of environmental contamination on health, or the care of the aged. The Foundation's inability to support such programs in no way implies a failure to recognize their importance, but is simply a consequence of the conviction that to make significant progress in the three problem areas described will depend in large measure on the Foundation's ability to concentrate its resources on them.

There are no formal grant application forms. Applicants should prepare a letter which states briefly and concisely the objectives and significance of the project, the program design, 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 which have qualified for exemption under Section 501(c) (3) of the Internal Revenue Code, and which are not "private foundations" as defined under Section 509(a). Public instrumentalities performing similar functions are also eligible.

Proposal letters should be addressed to:

Miss Margaret E. Mahoney, Vice President
The Robert Wood Johnson Foundation
P.O. Box 2316
Princeton, New Jersey 08540

Designed by Charles Curtis
Illustrations by Diane DeGroat
Printed in the United States of America
by Wm. F. Fell Company, Philadelphia

The Robert Wood Johnson Foundation—Princeton, New Jersey