The Robert Wood Johnson Foundation Annual Report 1973

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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.

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The president's statement

We have now had two years of experience working with groups and individuals seeking to move toward the objective we have selected for our initial attention: that of making effective health care more fully available to non-hospitalized Americans. That many are working toward this same goal is clearly evident from the proposals we are receiving. Consequently, the problem has become, how can we best select from the myriad of worthwhile plans before us, those which can best move this nation toward this goal? We hold as an article of faith that there are multiple appropriate ways to approach the problem, and our continuing studies and interactions with those in the health field and other disciplines have reinforced this belief. Improving access to personal health services, developing methods to ensure good qualitative standards of care for all, and collecting and disseminating the kinds of information which might help those responsible for resolving these thorny issues in the future are being imaginatively attacked from many directions. It is exciting to be partners in this important problem solving effort.

On the national scene, the problems of resource scarcity and the inability to keep up with demands continue to force difficult priority choices on those who work in health affairs. And how swiftly and abruptly this state of affairs seems to have come upon us! Suddenly, this affluent nation appears to have been thrust into a situation where, as recently stated on the cover of a national magazine, "we're running out of everything," and competition for resources, both public and private, is enormous. Sources of energy, beef, housing, and health care are in short supply, and difficult priority choices are having to be made. In the area of health, the choices are painful and unsettling. We have moved from an era when most innovative ideas were reasonably confident of receiving support, to a situation where basic problems which cry for attention have vastly outstripped the resources available to deal with them. A factor to be respected in any new plan of action is the degree to which the realities of this "scarcity" issue are taken into account. Consequently, where to place funds for the most public good is a troublesome problem which affects local, state, and federal institutions, and private foundations as well.

Obviously, it is far too early to make judgments about the ultimate merit of our initial selections. Changes in the ways of institutions

and in the ways of people come slowly. Fresh approaches take time to put in place, to gain acceptance, and to be assessed against what has gone before. So, many of our energies are even now being directed to developing methods which might permit objective evaluation of the avenues we have selected.

But, the very act of examining large numbers of proposals has yielded new information and new insights about the American health scene which have expanded our initial horizons. In our report last year, we presented our view of the American health scene in which we would operate. What we have supported and why we have done so form the basis of this report. How we might design and implement a careful review of these approaches seems a logical extension of our evolving program.

Improving access to health care

Our experience to date has strengthened our conviction that the lack of a dependable system of ambulatory front-line medical care represents the most pressing problem in health immediately confronting the American people. The term "primary care" is the current shorthand for describing the form of medical practice which we would like to strengthen. As usually employed, primary care describes care of a kind traditionally rendered by physicians in community practice. But this term does not convey as clearly as it should that the care we would like to encourage is a continuing affair. We are speaking of general medical care. It might be provided by internists, pediatricians, family practitioners, or by new combinations of physicians and other health professionals.

Obviously, the Foundation cannot decide for the nation what would be an ideal general care system and proceed to set it up. But we have attempted to visualize the key elements in a general care system, to analyze which forces at play represent constraints that should be challenged, and which forces are so fundamental that they should be strengthened and harnessed appropriately. Broadly speaking, we are trying to encourage modifications of what we now have and to select those modifications which can have wide applicability for the future medical care system of our nation.

What has been lost which must be restored is care close at hand, by a physician who knows us as an individual, who will see us on a drop-in basis, who has no great urge to send us to the hospital, and who can bring both personal support and science-based medical expertise to bear on our problems.

The remarkable advances in the science of medicine which can be applied to human illness make the restoration of the kind of first contact, general physician we once had not as easy as it appears at first blush. Modern medicine requires considerable technologic expertise and its constant updating. The general physician who provides

continuing care must dispense his or her services through a series of personal encounters, and one physician can have only so many patient encounters in each day.

Given the age, sex, and disease patterns of U.S. society, it is generally agreed that the size of a population which can be cared for by an individual in any such general practice ranges somewhere between 2,500 and 4,000 people. From this arises the dilemma. Serious illnesses are sufficiently infrequent in this size population group that it does not of itself provide the experience necessary for a physician to maintain his expertise. The continuing self-discipline required to remain current becomes particularly hard to mobilize when the expertise is to be kept "ticking over" largely on a standby basis rather than put to regular use. While the experience of some other countries suggests that it is possible to develop satisfying and challenging roles for those who do general front-line care, most young men and women entering the medical profession in this country have not gone this direction in recent years, and clearly new arrangements will be required to reverse the trend.

While the options available to attack the problem are multiple, they can be grouped under one of two broad rationales. Approaches of one type are based on the premise that many young American physicians fail to go into careers in general medical care because they are insufficiently exposed to it during their formative years and are not aware of its attractions. Here the thesis goes that if the proper individuals are selected for medical training, if they have some experience with general ambulatory practice during medical school and postgraduate training, more will enter the field. Approaches under the other rationale are based on the belief that the large scale avoidance of general care careers by physicians is a permanent phenomenon—that the requirements of modern medicine are irreconcilable with the generalist role for physicians. Those who adopt this premise believe we must develop new institutional forms and quite different professional support systems which will permit the function of general care to be properly served, and that we must find others to share in this role once served by the all-purpose physician. Obviously, these two points of view are not mutually exclusive, indeed, they are interdependent. Thus, we have chosen to support selected programs approaching the basic problem from both directions.

Following the premise that general medical practice can be a rewarding and fulfilling career for young Americans, part of our attention has been directed toward programs designed to attract more physicians to careers in general medical practice. The presence of the physician—particularly in combination with other kinds of health practitioners who can broaden the scope of services offered—is the key to whether a community will have ready entry to medical care. Regional planning, or efforts at cost control, or planning financing mechanisms, are

Physicians who know us as individuals

empty exercises if basic medical talent is not available. Consequently, some of our efforts have been directed at enlarging this "generalist" physician pool. These have included selected postgraduate residency training programs designed to encourage careers in general medicine, certain programs which we hope will attract more medical students to general care practices, and the efforts of a few academic medical centers to develop new opportunities for medical students and young physicians to gain experience with primary health care delivery in urban and rural areas.

We have also been interested in programs predicated on the other thesis; namely, that improvement in the delivery of general health care can be best fostered by the development of new systems of practice and professional support which might better serve primary ambulatory care functions. By this we mean the system whereby the physician is linked to the world of scientific and professional knowledge and to the practical day-to-day workings of the health system. Thus, programs testing reallocation of responsibilities among physicians, or among physicians and other new kinds of health professionals functioning in ambulatory care, have received support.

The problems of the delivery of effective health care services are vastly different in urban and rural America. In urban inner cities, the fragmentation of families, the reliance on hospital emergency rooms for episodic care, and the difficulties in obtaining close-at-hand health care, especially at night because of the hazards of movement through the inner city, are all important deterrents to developing comprehensive personalized health services. Some community groups and inner city hospitals are receiving our help with their efforts to overcome these difficulties.

Access to health care in rural America is quite another problem. Put simply, rural America has less of almost everything except land area—less money, less trained leadership, fewer physicians (or, indeed, professionals of all sorts), and, since 1920, fewer people. While the most critical health resource needed is primary care manpower, we have concluded along with others that simply producing and attempting to recruit more doctors for rural America will not by itself improve access to primary care. In our judgment, the solo general practitioner working in isolation is no longer a feasible solution to the problems of care that rural communities are experiencing. Thus, we are supporting programs which are developing team practice settings staffed by combinations of primary physicians and other health professionals with strong linkages to larger, more complex medical care organizations.

The increasing number of young physicians indicating an interest in hospital-related group practice has implications for both rural and urban areas, since America has a network of 7,000 community hospitals dispersed across the nation. In many parts of the country


Rural America
The problem: less money —
fewer physicians

the community hospital has the potential for bringing together many facets of its community in a common cause—its civic leaders, physicians, nurses, and community organizations, who feel a real responsibility for community health needs. Thus, community hospitals can be powerful potential forces for change. Despite their serious financial difficulties many of them are currently attempting to become more than simply inpatient institutions. Some appear to have the potential for developing affiliated group practices which might serve as a single identifiable source of continuing ambulatory care for the whole family, with round-the-clock front-line coverage and an integrated and coordinated referral system. Consequently, we have encouraged a few community hospitals which are moving this direction. They vary widely in location and clientele. Some deal with upper middle class citizens in suburban America, some with the rural poor, and some with blue collar inner city people. The common thread is a desire to improve the local organization and delivery of personal health services.

As it now stands, there is a tendency for physicians to move into higher income areas where other physicians are often already located rather than to seek out low settlement areas. Overpopulation of an area by physicians does not correct itself because, in contrast to most fields, it seems that in medical care, supply can create its own demand. Certain constraints often prevent physicians from moving into areas of need even when personally interested in doing so. There is often not enough money in such an area to allow a physician to earn a living and to break even in his or her practice. Further, in the absence of some support to offset deficits, practices in such areas often have to cut back on free care and the range of services offered, thus failing to meet the needs of the community for which the practice was designed. In an effort to help alleviate these problems, the Foundation is supporting a few independent nonprofit organizations to cover the development and startup costs needed to establish new group primary care practices in areas now without adequate health coverage.

In recent years, substantial interest of both those who give and those who receive care has centered on prepaid group practices for groups of people who have contracted in advance for all of their medical services. This form of practice, now popularly called a health maintenance organization, has been in existence since the 1940's, and at least 7 million people now receive health care from some 30 such programs in the United States. Studies to date have shown that these prepaid group practices appear to use less hospital care, have fewer premature births, fewer infant deaths, and lower costs than other modes of practice. While there is no reason to believe that the health maintenance organization is a panacea for all of the nation's health care problems, they have stronger cost control features, offer

another choice to individuals in ways to pay for and receive care, and are compatible with the American desire for pluralism. Thus, a few university-based or affiliated HMO's are receiving assistance. Hopefully, federal legislation passed in late 1973 will permit a broader test of this form of medical organization.

Special problems of access to care

The absence of certain basic medical services for particular groups represents a glaring defect in our system of medical care. Because the necessary technology is known and defined, and because organization of these special kinds of general services encourages regional coordination of health care, the Foundation has made funds available for several programs targeted at special high need groups.

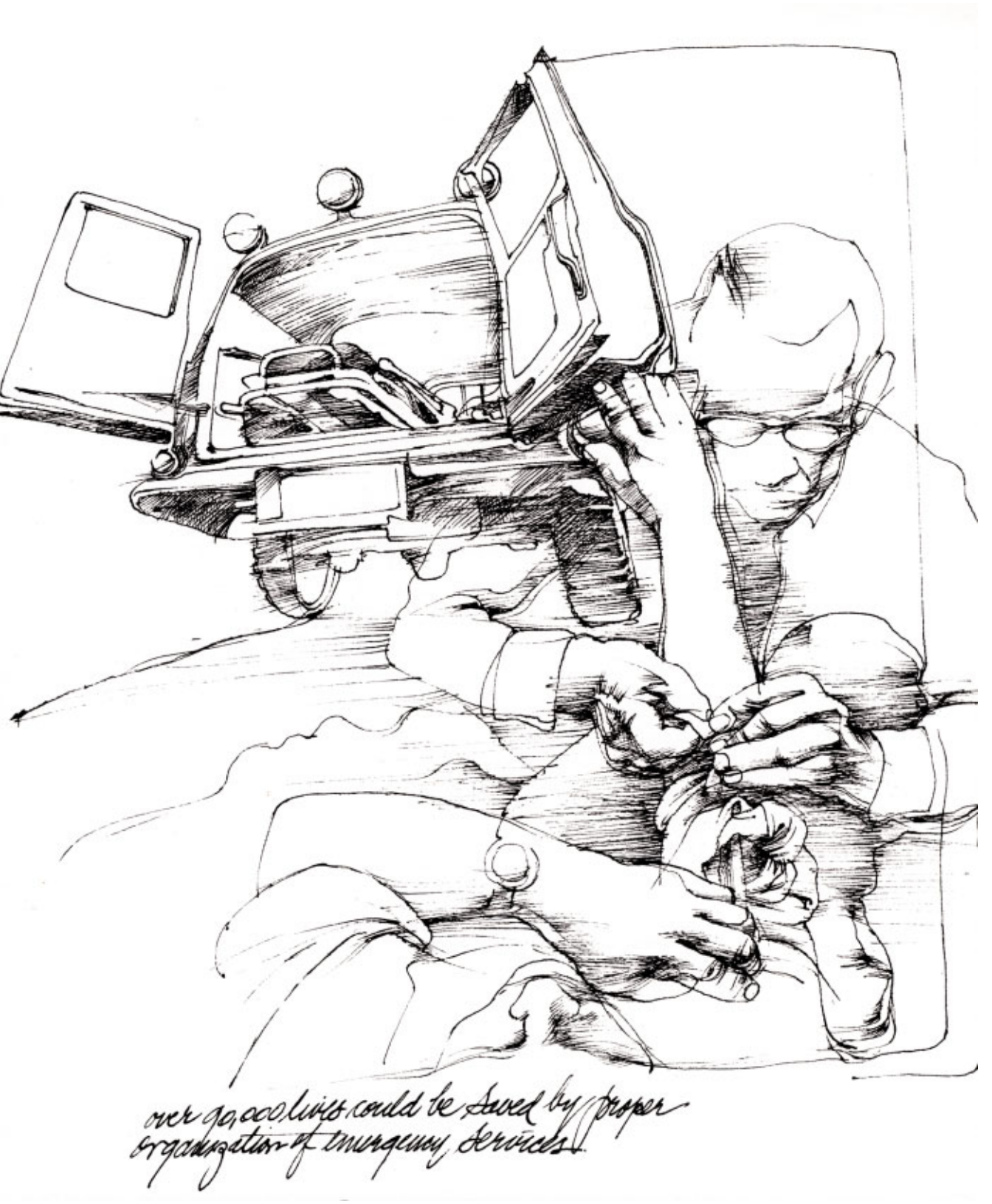
Emergency medical care

The difficulty many people face in getting immediate and appropriate emergency medical care is a particularly severe problem in the United States. Each year in this country over 115,000 people die from accidents, and more than 50 million are injured. It is estimated that as many as 90,000 lives a year could be saved with proper organization of the services available. A number of national studies have shown that the difficulties arise largely from the structure of the American health system where the responsibilities for emergency medical care are divided among many private institutions and governmental bodies. Today in most parts of this country the individual has no central place to call when emergency medical assistance is required, few emergency vehicles have direct communication links between the scene of the emergency and the hospital and, where communications systems do exist, many are fragmented along a variety of jurisdictional lines which often means that the appropriate site of care cannot be alerted to prepare for the arrival of a patient with a particular problem. Thus, victims of a serious highway accident often arrive at a hospital unprepared by advance warning, patients with serious head injuries may be taken to a hospital lacking neurosurgical coverage, or a seriously burned patient may not end up in the only regional hospital with a sophisticated burn unit.

Experts are now agreed that rapid and appropriate access to emergency care can be provided if regionally based response systems designed to integrate an area's emergency care resources into a comprehensive network are established. The Foundation has thus launched a program to permit regions to develop well planned regional emergency medical response systems to coordinate emergency and disaster medical services throughout relatively large geographic areas or population centers.

Child health care

Although we generally believe as a nation that we pay careful attention to our children, child health has been surprisingly neglected in the


over 90,000 lives could be saved by proper
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public arena. Over 100,000 young children die each year, many from preventable or remediable causes. Indeed, the risk of death is higher during the first year than in any other age group under 65. Approximately 25 per cent of all young children have speech, hearing, or vision impairment. Many of these children could dramatically benefit from access to adequate medical care, yet evidence exists to suggest that those most in need of care are the least likely to receive it. Because of the obvious fact that the health of any adult population depends on the quality of care rendered in infancy and childhood, the Foundation is examining certain kinds of programs which give special emphasis to the problems of this age group.

Perinatal and neonatal care

There is also a body of new knowledge which suggests that we could significantly improve the outcome of certain pregnancies so that children not only survive, but have maximum potential for both mental and physical growth. Events surrounding the period in utero and at the time of birth are critical and contribute to the risk of an infant's becoming one of the 100,000-200,000 neurologically damaged or mentally retarded born each year.

In any group of pregnant women somewhere between 12-30 per cent will be found to have some findings that indicate trouble may be along the way for either the unborn child or the mother. It appears that a variety of neurologic disabilities which occur most often in infants of low birth weight can be sharply reduced by identification of these pregnancies, and their careful management through delivery. What appears to be needed is a region wide intake system in which all pregnant women can be examined for evidences of high risk, their situations periodically checked, and those who remain in the high risk group admitted to centers which have the personnel and equipment for highly specialized types of care.

Because of the impressive evidence that significant advances can be made in this area, the Foundation is in the process of developing a program of a limited number of regional demonstration networks to provide obstetrical, perinatal, and postnatal care for defined populations. This special program will take shape during 1974.

Improving the quality of care

Too few are working in the difficult area of developing better indices of the quality of health care delivered to Americans. This is understandable, for the methodologies are few, just what constitutes acceptable medical care in certain situations is controversial, and measurement of the effects takes time. New technologies and life support systems have also raised pressing moral and ethical problems. The increased capacity to prolong life, transplant organs, to use genetic

information to determine the outcome of pregnancies, to regulate behavior, or control fertility are scientific advances which have enormous potential consequences for mankind and pose troublesome new questions for medicine and society at large.

Thus, quality assessment, despite the complexities involved, has become a burning issue in this country. Vague and poorly defined concepts of measuring quality simply must be improved and transplanted into operational terms if we are to determine whether attempts to improve personal health services actually improve the health of people. Care in selecting the methods of assessing quality is of utmost importance, for the methods used may well determine the results obtained. Selection of inappropriate measurements could lead to the wasteful expenditure of huge sums on ineffective medical care, or conversely, could standardize levels of care well below what modern medicine can actually provide. We are thus trying to encourage a number of approaches in this area.

The need for a cadre of clinically oriented physicians with new skills borrowed from the management sciences, economics, business, law, or public health who can better attack the very complex problems of planning, organizing, and running health care affairs in this country is well recognized. This need led to the development of The Robert Wood Johnson Clinical Scholars program to permit a small number of physicians in training to acquire new tools to work more effectively in these areas. With the same rationale, support for a program designed to improve the management skills of those who are responsible for academic medical centers, a center to give special kinds of analytic training and services to those working in health, and a few programs offering advanced study in health economics and the sociologic problems in health care systems have also received support.

Promising techniques for assessing the level of care given in communities or groups are now being developed and tested. These kinds of analyses are long overdue and we are aiding in their application to operational settings. Some specialty groups are also conducting careful studies of the quality of their services and the requirements for same. Serious questions about the benefit and risks of a number of clinical procedures now in wide use are being raised, and at long last, receiving objective study. In our judgment, these kinds of information should aid in improving the quality of health services.

It is self-evident that the behavior of the individual to a large extent determines his or her health. Thus, on the consumer side, a major effort using educational TV to deliver health information in an attractive and entertaining manner of a kind which individuals can utilize to improve their personal health habits is also being tested and evaluated.

Broadening public policy options in health affairs

The virtual absence of any well understood, generally agreed upon, comprehensive long-range blueprint for the health care future of American society is well recognized and a tragic paradox in this technically advanced nation. We need a set of priorities, and plans to move toward them, that all understand. Consequently, the Foundation has chosen to help fill this void by encouraging selected groups and individuals who are attempting to study, evaluate, and develop clearer options for directions in public policy in health affairs. Believing that better national planning for health care is fundamental to the success of the objectives we have selected has led us to focus on the development of basic capacities for policy and legislative analysis, and on the selection of groups capable of translating their findings in these areas into the kinds of information needed by those responsible for policy choices.

Practicing health professionals, by virtue of their intense involvement in individual patient care, have important insights much needed in planning future health care for America, but much of the planning is being done without their advice. Efforts of certain private and voluntary organizations to become more effective and useful in the planning process have also received assistance.

In short, we are attempting to develop an organized program in the public policy field to strengthen the nation's decision making capacity at all levels, both public and private. In order to do this we are concentrating on applied research, training of young professionals, strengthening certain private groups involved in planning, and ways of disseminating the results of these labors. Our fundamental objective is to improve this nation's ability to make knowledgeable choices about health matters and to be better able to deal with present and future problems in health.

The problems of financing ambulatory out-of-hospital health care programs

A serious problem faced by those undertaking the development of new methods for delivering general medical care and the more effective deployment of medical care services is the gloomy prospect for financial self-sufficiency for many such programs. Our projections suggest that financing will prove a serious problem in years to come unless more adequate mechanisms for paying for office and outpatient care emerge. The problems become obvious when one considers the following data.

In the United States today there are 25.5 million people living below the poverty line and another 10 million who are classified as being "near poor." An estimated 40 per cent of these 35.5 million people are not covered by either Medicare or Medicaid programs. Medicare and Medicaid coverage varies widely among states and in


health of adult population
depends on quality of child care

some, only small amounts of public financing are available for ambulatory care programs. Thus, in only a few areas can new ambulatory care projects serving low income groups expect to become economically self-sufficient.

Ambulatory care programs for those with greater financial resources are also not exempt from this dilemma. Significant numbers of moderate income people do not have substantial out-of-hospital insurance coverage. Indeed, half of the families below an income level of $5,000 a year have no health insurance at all. Thus, many millions of Americans whose incomes are above the "poverty level" are nevertheless "medically indigent" and are generally unable to sustain substantial out-of-pocket costs for personal health services.

The problem of financing new health programs in underserved areas is further compounded by the fact that low and moderate income families who are unable to pay personally for care are not proportionately distributed throughout the country. They tend to be located in rural communities and inner city ghettos. This makes it particularly difficult to launch new programs in the underdoctored communities where the greatest unmet needs reside. In many of our cities, the progressive segregation of the poor means that the poverty areas include very large sections of the city with virtually no intervening areas of non-poverty. Thus, even when the poverty is not extreme, attempts at change in the area are often immediately engulfed in the enormity of the needs and they fail to survive.

It is a simple fact that the governmental insurance programs were not designed to finance comprehensive general medical care provided outside of hospitals. Medicare, which now pays about 40 per cent of the total costs of medical care for the aged, uses funds primarily for hospital care and inpatient physician services. Similarly, in most states, Medicaid has limited rates of reimbursement which generally prohibit comprehensive ambulatory service programs from becoming self-sufficient in low income areas. Indeed, a recent study reviewing the financial situation of five types of federally supported ambulatory care centers concluded that the centers could never approach self-sufficiency and that even optimal management could probably not result in collection of more than 20 to 25 per cent of their operating costs.

Paradoxically, recognition of these serious financial constraints has strengthened our conviction that effective new ambulatory care systems must be put in operation if efforts to develop adequate financing mechanisms are to be accelerated. In many instances, the science and technology which now exists could swiftly improve the state of health affairs. But simply the existence of the technology does not guarantee its use. All too often, systems for its use are lacking. Therefore, efforts to create better systems and to demonstrate clearly how the technologies can be applied to a community or a region at

reasonable cost may be a necessary forerunner to developing better ways of paying for it.

But, the obvious question for this Foundation is, "What should be our posture during the period when a national health financing mechanism simply does not exist?" Clearly, denying funds to new ambulatory programs for underserved areas where low income citizens live comes in direct conflict with the Foundation's programmatic and humanitarian goals. But the facts outlined above are forcing us to develop a series of guidelines which will enable us to continue to aid selected programs which we feel can serve as models to be replicated when better national financing of ambulatory care becomes available. For, despite the size of the Foundation's assets and our national orientation, we are simply not able to meet the totality of local needs which face the nation in this sector.

Developing new knowledge about problems in health and medical care—the education of the Foundation

Our efforts to date have made us vividly aware of the enormous gaps in our knowledge about health, health care, and health care practices in the United States. The vast flow of information we receive from our constituents, coupled with staff explorations of problems, frequently leads us to the realization that more data simply must be developed in a particular area before rational directions or strategies can be plotted. Thus, in the course of our activities during the year, we have supported a number of program-related studies which will lead to the development of books, monographs, and articles on subjects on which more solid information is needed. These efforts are aimed at improving the nation's ability to develop the critical issues in the field of health and, more specifically, to evaluate Foundation programs which have been developed in response to those issues.

While industry-wide research and development is not new, the staff and trustees of The Robert Wood Johnson Foundation have agreed on a style of operation in which we support demonstration programs as proposed solutions to health problems, provide mechanisms for evaluating those demonstrations, and offer this information to others working in health affairs. The concept then is of a foundation that has an explicit built-in evolutionary mechanism; that uses scientific research as a basis for developing its future programs.

Attempting to get scientific answers about the impact of policies and programs in the social arena is relatively new and has not been widely explored. Broadly speaking, we are supporting programs which might be entitled "conclusion oriented research" in which the aim of a project is to arrive at an understanding of the state of affairs in a particular field, "decision oriented research" in which we hope to gain information to guide us in policy choices, and "evaluation oriented research" to determine whether or not particular programs successfully

carried out their original intent. In developing this program we plan to allocate a portion of Foundation funds for the purpose of securing such analytic and evaluation services from independent groups, with the hope that our own programs and those of others will be materially improved.

Evaluation of Foundation programs

So much for the vessels we have helped to send down to the sea this year. We have indicated some of the rocks and shoals which concern us, and have detailed some of our initial efforts to become wiser advisors. Whether the vessels we have encouraged to embark will safely make port we do not know. Perhaps in attempting to facilitate change this is all that can be done—to launch the ships and after 8 to 10 years look to see which ones made the trip successfully. But in our increasingly priority conscious world this passive approach would be irresponsible, and we must try to evaluate their journeys.

While the evaluation of programs designed to alter the way institutions and people act cannot yet be classified as a science, the staff and trustees have agreed that we must develop thoughtful, professional ways of weighing the effectiveness of our various programs. Clearly, our society will require solid objective data which demonstrate the worth of a particular program if it is to be widely accepted, transported to other regions, or publicly financed. Consequently, we have spent a considerable amount of time trying to develop an understanding of the assessment process. We fully recognize that we have no well-tested prescription for this exercise but we have chosen some ways to start. It thus seems appropriate to close this report by presenting this thinking and the plans based upon it, with the recognition that time and experience will measure the wisdom of our choices.

Evaluations have widely differing degrees of complexity. They vary in duration, sophistication, and expense. They can be roughly separated into three groupings and characterized by the kinds of questions they ask and the audiences for which they are designed.

The simplest, or first level evaluations, attempt to answer the question, "How well was the task carried out by those who conducted the program?" In general, this is the kind of evaluation carried out by many groups in our society. In the foundation field, data are needed to answer in-house questions raised by foundation staff and trustees in deciding whether to renew or terminate a particular project. The goal is to assess the quality of the performance. The assumption that the overall direction of the project supported was a worthwhile attempt to solve a particular problem is accepted. Quite understandably in our area of focus, health professionals can often be quite critical of this kind of first level evaluation, for they often wonder whether programs judged to perform very well in the eyes of those who launched them have had much real effect on health or on the way health care is actually delivered.

Second level evaluations ask a different question, "Did a particular program change the way individuals or institutions acted after the program was in place?" Here the evaluation is oriented toward an external group. In the Foundation's situation, this is the national health professional community. This group is, in general, not concerned with how well a foundation carried out its programs, but rather with whether the project improved or changed the attitudes or behavior of health professionals and their institutions.

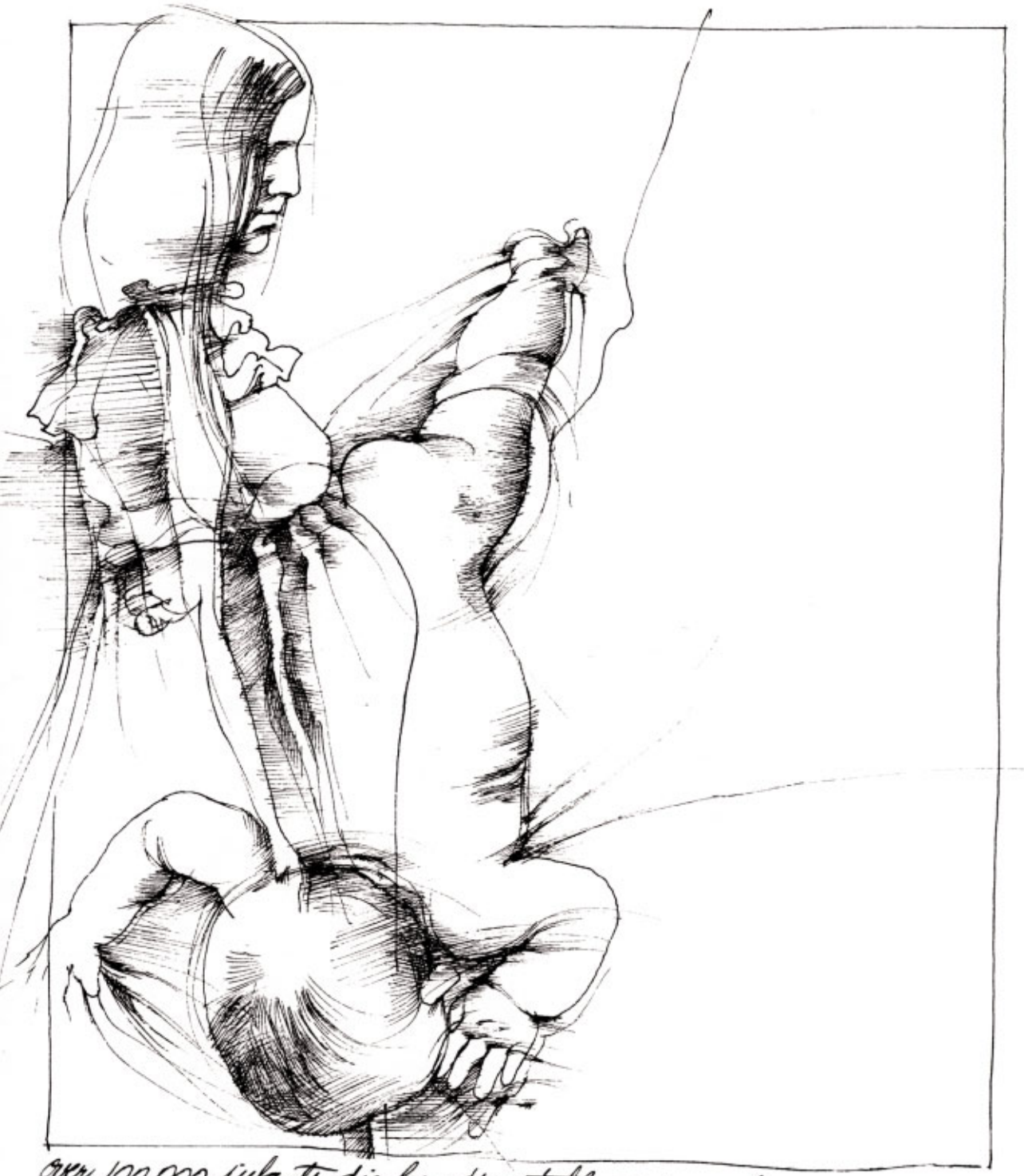
Third level evaluations ask still a different set of questions and are oriented to the concerns of a broader national audience—those groups and institutions which play a dominant role in the formulation of the nation's health policies and who often make the decisions regarding the flow of new resources to any social welfare field. Quite logically, the questions posed by this group relate to what impact a particular program had on the quality of people's lives. Often they ask, "Would additional expenditures of money to reproduce a particular program improve the welfare of people generally?" Here the concerns are not how well the initiators of the project performed, or with the effect of particular programs on the behavior of health professionals and institutions, but with a more basic question: "Did it improve people's lives?" Thus, third level evaluations are those of most substantial importance to those who must formulate public policy.

As an example, a foundation might make a grant to a school of medicine to establish a primary care teaching program. A first level evaluation would ask, "How well did the school carry out the program? Were the records well designed? Was the program well laid out and the curriculum carefully planned? Did experts feel that the patient care management was satisfactory?"

A second level evaluation would ask very different questions. It would ask, "Did the program change the attitudes of medical students regarding primary care? Are they more willing to enter careers in this area? Has it raised the interest and attention given to primary care in the medical school as a whole?" Obviously, these questions would be of major concern to the professional community before recommending the expansion of such programs to other academic medical centers.

Third level evaluations would ask, not how well was the program carried out nor what did it do to change health professionals, but rather, "What did the program do to increase the number of new physicians entering primary care? What was its long-term success in placing graduates in areas of need? Did it increase the satisfactions and the health of those receiving care?"

Obviously, each of these kinds of questions and each of these concerns are legitimate. Different groups are responsible for different levels of decision making within the health field, and the kinds of information each group needs before making decisions vary, but are growing more


over 100,000 infants die from preventable causes each year.

rigorous. The facts that projects were carried out well or *seemed* to help people are no longer satisfactory answers in many sectors. Consequently, those who must dispense the resources necessary to widely implement "demonstration projects" deserve answers to the deceptively simple question, "What did it do for people?", before programs are accepted or implemented in communities across the nation.

As is apparent from above, second and third level evaluations are complex, require sophisticated tools, adequate resources, and sufficient time to do the job. Applied to the health field, they are fraught with a number of potential pitfalls and hazards.

First, many of the indicators which are used to assess the introduction of new health care programs are not sufficiently sensitive to the immediate effects of change on people's lives to give convincing answers, and considerable research and development will be required if this problem is to be overcome.

Second, many new programs lack sufficient critical mass to permit drawing significant conclusions from the results of an evaluation. Consequently, expert help is often needed to determine "how much is enough" in a program area to obtain answers of sufficient clarity to permit solid conclusions. The answer to this question is usually calculated in advance in scientific work in biology, but this approach has been infrequent in social areas.

Third, most institutions lack the resources to support evaluative studies which require significant expenditures and a considerable amount of time to complete. Second and third level evaluations often require planning well before a program is initiated and a significant follow up period to determine its impact. This is understandably difficult, and sometimes impossible to do.

Fourth, one of the potential hazards of assessment in the arena of social change is that of premature evaluation, particularly when no groundwork has been laid for it. For instance, a change in the design of undergraduate medical education aimed at affecting where students will later practice will require solid knowledge of what has gone before, what happens to students not involved in the program who are growing up in other educational settings, and an 8- to 10-year period to determine its effectiveness.

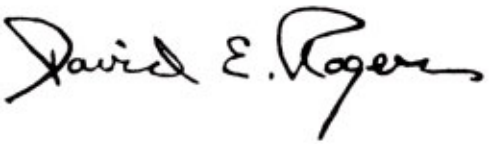
Last, "objective" evaluations which involve quite subjective and intangible aspects about people often miss the mark. It is part of our deficiency in not having arrived at a genuinely human science for human beings. Part of the difficulty is that if something quite good has brought about new and significant types of behavior, we can only measure such behavior in terms of old, and now quite "insignificant," types of behavior. We often measure "the thing next to the thing we really want to know."

Recognizing these problems, The Robert Wood Johnson Foundation staff and trustees have, nevertheless, decided that second and third

level studies will be attempted under certain circumstances. Our rather specific focus and our resources permit us this privilege. Worse than failure would be not to attempt it. Where projects are of sufficient scale, where they are being conducted simultaneously at a number of sites, and where there is reason to believe that measurable end points can show the effectiveness or lack of it within a reasonable span of time, we shall undertake such studies.

These are our hopes. Only experience will determine if they can be fulfilled. So far we have initiated four such evaluations, each conducted by an independent external group. These studies are in progress, and are described in the succeeding review of specific programs.

Last year we reported our conviction that the greatest deficiency in health faced by this country was the absence of an equitable system of access to care of respectable quality for all citizens. During this past year we have acquired a fuller understanding of the multiple requirements which must be met for such a system to be acceptable and potentially capable of replication. Perhaps with the innocence of the novitiate, we have now indicated how a start is to be made on evaluation of programs we have encouraged. Each of these efforts, and those which will follow, represent the first steps of a new foundation trying to discharge its obligations in a responsible and responsive fashion. In subsequent years, we will be reporting the results of these assessments to those who serve the health care needs of America, and the rest of our constituency, the American public, who deserve the best we can collectively put together.



Description of selected grants

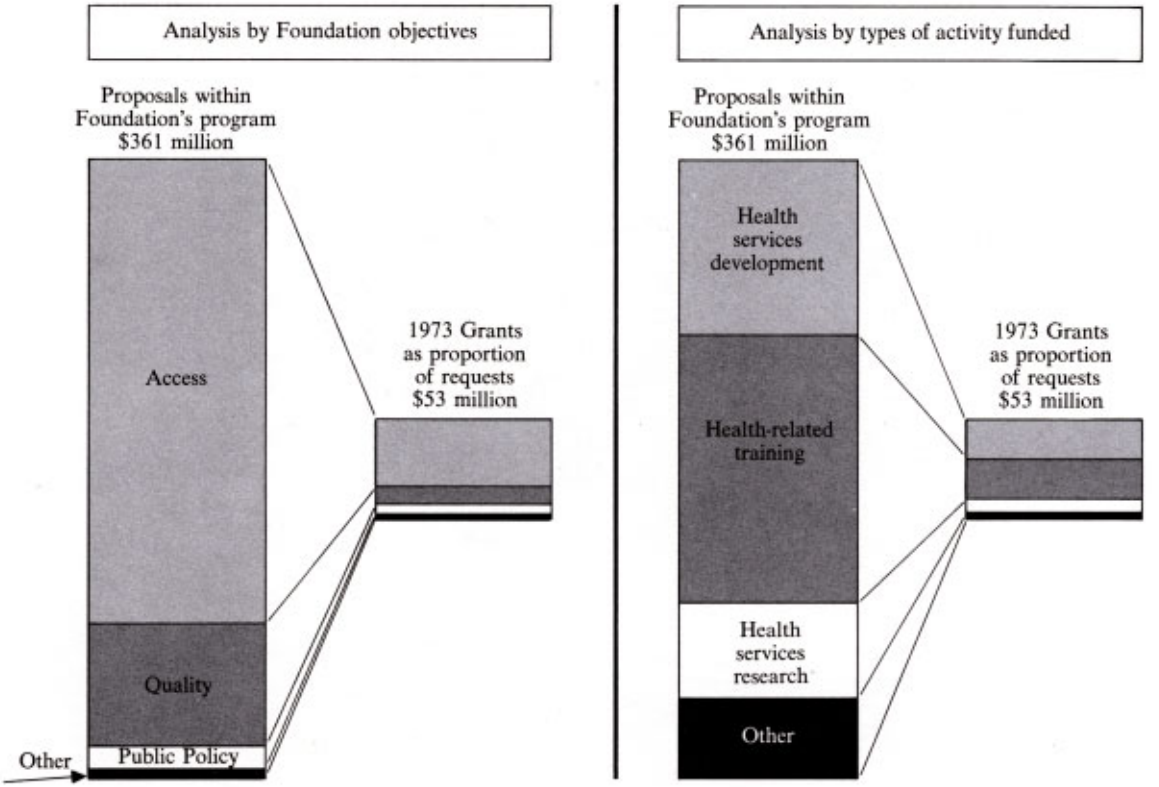
Description of selected grants

The grants described on the following pages have been selected to give a view of a much larger number of projects directed to the Foundation's three program objectives: improving access to out-of-hospital general medical care, the quality of care, and the information required to make more effective policy choices in health.

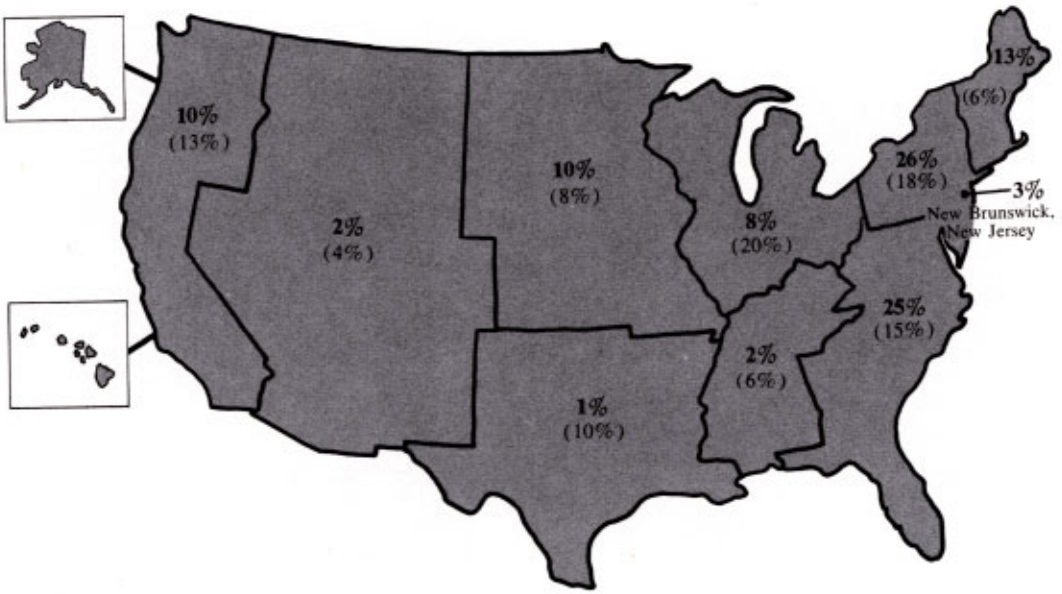
The 124 grants awarded by the Foundation in 1973 represent a commitment of nearly $53 million. Of this total, efforts to improve access to primary care received $40.7 million. Projects to improve the quality of American health care received $5.3 million. Projects in public policy research and analysis were awarded $6.2 million. Other projects, including those in the New Brunswick, New Jersey Area where the Foundation maintains an historic and continuing interest, received $836,000. A complete listing of grants by institutional recipient appears on page 58.

In 1973, the Foundation received approximately 3,500 proposals representing requests in excess of $600 million. Those proposals which were directed to concerns within the Foundation's program objectives would have required $361 million to implement. The Foundation was therefore in the unhappy position of disappointing the majority of applicants, many with meritorious programs. The accompanying charts indicate that the Foundation's resources supported only about 15 per cent of the funds requested, and indicate the geographic distribution and the types of institutions receiving support during 1973.

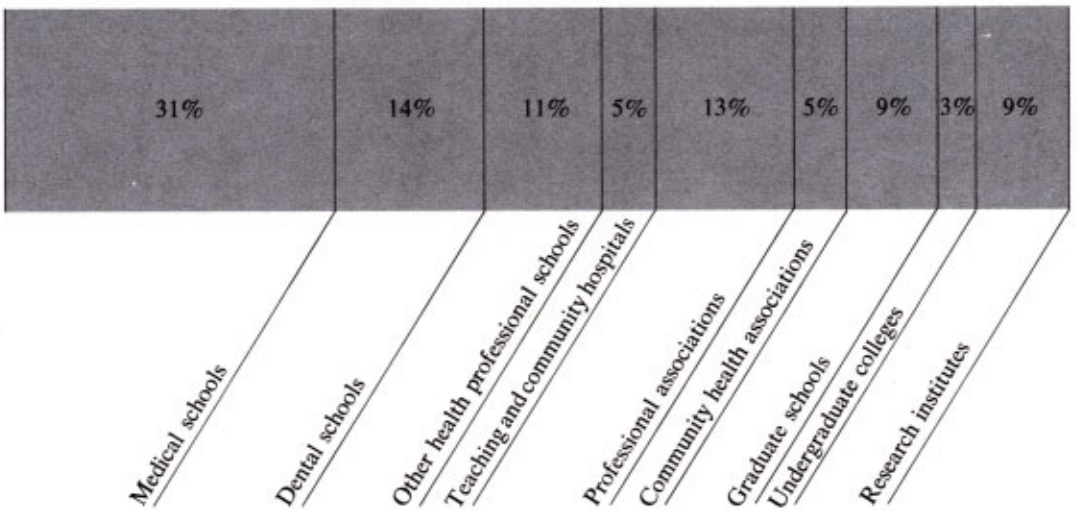
Analysis of the Foundation's 1973 grants



Distribution of Foundation's 1973 grants by geographic region.
Percentage in parenthesis indicates percentage of total U.S. population in a region.



Distribution of the Foundation's 1973 grants by type of institution



Access to primary care

To improve access to primary care, the Foundation has supported professional school programs to prepare more physicians for careers in general medicine, and projects to develop new types of practice arrangements in which such graduates can hopefully improve current methods for delivering primary care.

Strengthening professional education in primary care

Recognition of the need for more physicians specifically prepared for careers in primary care has prompted a number of medical centers to develop stronger and broader teaching programs in ambulatory care to complement their hospital-based training programs. These new medical education programs offer new career options in internal medicine, pediatrics, and family practice to young physicians during their pre- and post-graduate professional training periods.

Medical centers at four universities—George Washington University, Harvard University, Washington University in St. Louis, and the University of Rochester—started such ambulatory care teaching programs with Foundation support in 1973.

The program developed by the School of Medicine and the School of Nursing at the University of Rochester, New York, illustrates this kind of approach. There, new training programs will emphasize the use of joint practice teams in delivering health care. Each practice team will be assigned to one of several Rochester health centers and will be responsible for organizing and supervising the total health care needs of a group of patients, including the period of hospitalization. Both medical residents and nurses will become familiar with the appropriate clinical and laboratory skills needed to diagnose, treat, and manage acute and chronic medical problems. They will also gain experience with new types of medical records and data systems which can isolate illness patterns and help to define the practice demographically. The practice team nursing students will not have the usual kinds of fixed duty schedules traditionally used in nursing, but will share with the residents responsibility for round-the-clock coverage of the practice.

At Washington University in St. Louis, Missouri, a prepaid group practice to serve as the base for an ambulatory care training program has been established. Physicians staffing the group practice will have principal responsibility for training residents and interns interested in careers in general medicine. At George Washington University in Washington, D.C., residents enrolled in a new curriculum will spend most of their first year learning how to manage non-acute hospital patients. The second and third years will be spent in one of several ambulatory practice sites, including family health centers in rural and urban areas. Within the Harvard Medical School complex, three of Boston's major teaching hospitals—Massachusetts General, Peter Bent Brigham, and Beth Israel—are developing a new program to prepare young physicians for careers in general medicine. The program will emphasize family and child care as well as the use of mid-level health practitioners in delivering care. The training will take place in the ambulatory care units of these hospitals, local neighborhood health centers, and the prepaid group practice organized by the Harvard Community Health Plan.

Developing new primary care practice systems

The Foundation has also assisted in the concurrent development of new methods for the organization and delivery of primary care which will attract and retain these new physicians, especially in communities where basic medical services are scarce.

For example, two young men from eastern Kentucky—a physician and a former dean at a local community college—organized the East Kentucky Health Services Center in the small town of Hindman, Kentucky, to provide a comprehensive system of care, including care in the homes of patients, home health education, and dental care. The health center is the community's link to other medical services, including a community hospital and the consultative services of the University of Kentucky Medical School.

The health center staff includes two physicians, a dentist, a pharmacist, four clinic nurses, four nurse practitioners for the home care program, and five community health aides trained to help neighbors with health problems. In the summer months, college students from the region assist the center's health screening program and counsel families in health maintenance. Medical students from a number of institutions will soon be spending part of their senior year at the health center in Hindman to learn first-hand about physician and patient needs in a rural area.

The Foundation also assisted several other non-profit community sponsored group practices, including the Cottonwood Health Group, Inc. in Tekamah, Nebraska, the Matthew Thornton Health Center in Nashua, New Hampshire, and the Glenville Health Association in Cleveland, Ohio.

A number of programs developed by academic medical centers to create group practices which can improve medical care services on a regional basis, and serve as locations for ambulatory care training programs for medical students and other professionals, received Foundation support during the year.

As examples: the University of Florida College of Medicine at Gainesville, is planning a health service program covering a four-county region of 25,000 people in rural North Florida; the Rush Medical Center in Chicago is building a large, cooperative urban network of institutions to develop their new system of education and community service in primary care. When fully realized, the Rush regional program will unite teaching institutions, community hospitals, and neighborhood clinics to serve over one million people in the Chicago area.

Other institutions examining new roles in ambulatory medical care include Cornell University Medical College in New York City, the College of Medicine and Dentistry of New Jersey, Jefferson Medical College in Philadelphia, the Maine Medical Center in Portland, the University of Nebraska, and Tuskegee Institute in Alabama.

A third approach to the problem of improving access to primary care is being developed by some community hospitals, which are moving to establish new ambulatory care programs. Because of their wide distribution throughout the nation, community hospitals can be an important resource, providing the administrative and technological support needed to attract, organize, and deploy new primary care medical personnel.

One example is the Genesee Hospital in Rochester, New York. Two years ago, the Genesee Hospital established the Genesee Health Service as the hospital's ambulatory division, and staffed it with full-time salaried physicians and other health professionals to provide comprehensive care for its patients, many of whom had relied upon the hospital's outpatient clinics for routine care.

Once this hospital-based health center was well established, Genesee Hospital decided to develop other ambulatory units in the region. Basic medical care and patient management at these new units will be provided by physicians assistants and Genesee Health Service physicians. A Foundation grant in 1973 assisted in beginning the first of these small practice clinics.

Also with Foundation support, St. Joseph Hospital and Presbyterian Hospital Center in Albuquerque joined forces to sponsor three new clinics in rural central New Mexico. The

clinics will be staffed by nurse practitioners who will receive supervision from cooperating physicians in private practice in Albuquerque, with the hospitals providing each clinic with supporting services and administrative assistance.

In Evanston, Illinois, a Northshore suburb of Chicago, a non-profit corporation sponsored by residents of Evanston initiated plans for a family health center devoted to primary care. The health center planned by Evanston Medical Consumers, Inc., with the assistance of the Evanston Hospital and the Foundation, will be a multi-specialty practice staffed by full-time salaried physicians and other health professionals.

Preparing new health professionals for primary care practice

The Foundation also supported the training of non-physician professionals to assume many of the routine functions customarily performed by physicians, in a limited number of programs where the education is conducted jointly with medical students.

Johns Hopkins University has established a new School for Health Services, the first specifically established within a major medical complex for the training of mid-level health practitioners. Students enrolled in the health associates program supported by the Foundation will receive the baccalaureate degree, and will be qualified to provide a major portion of patient care under physician supervision. They are joined by medical students during their educational experience.

The Foundation also supported two existing regional training programs with success in placing new health practitioners in service with primary care doctors in rural areas. The School of Medicine at the Davis campus of the University of California is training family nurse practitioners who will work with physicians in rural communities in central and northern California. A second regional training program, at Alderson-Broaddus College in Philippi, West Virginia, prepares students from the Appalachian area for service as physicians assistants in their home communities.

Special problems of access to primary care

As noted in the preceding section of this report, there are a number of situations or particular groups in society who experience special problems in obtaining appropriate primary care attention. Three areas received attention in 1973.

Emergency medical response systems

The Foundation is sponsoring a two-year $15 million program to establish regional emergency response systems throughout the nation as a means of getting prompt and effective treatment to accident victims and those facing other medical emergencies.

About 50 American communities will receive grants for the organization of regional programs functioning under a unified communications network. The regional programs to be financed under this competitive program must demonstrate a plan that includes immediate citizen access to the emergency medical system through a well-publicized call number, such as 911; medically controlled dispatch of appropriate vehicles and services, and transport of patients to previously alerted facilities; and area-wide coordination among hospital emergency rooms, ambulance services, emergency cardiac care units, and burn and poison centers. Priority is being given to proposals that cover the largest geographic or population areas and provide strong linkages between the medical care system and sources of emergency medical aid.

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 the program.

Dental care for the handicapped

To increase the number of community dentists prepared to care for the physically and mentally handicapped, the Foundation initiated a $4.7 million competitive program to encourage dental schools to introduce into the curriculum a carefully planned classroom and clinical experience in the treatment of the handicapped.

Under the program, eleven dental schools will receive funds over a four-year period to design appropriate courses and secure the faculty and special equipment needed to provide effective training in the care of the handicapped. Priority is being given those programs which have previously demonstrated a concern for the care of the handicapped; those which serve a large geographic region or population base; and those which provide treatment for patients from all age groups suffering from a wide variety of crippling conditions.

The American Fund for Dental Education in Chicago is administering the program.

Child health care

The Foundation's activities in child health are concerned with the development of a coherent health system which ensures proper parental and medical attention throughout a child's growth and development.

Such an approach in primary care services is being developed for children and youth in New York City by the Mount Sinai School of Medicine, and more recently by the Columbia University College of Physicians and Surgeons.

Based on a four-year program of involvement in the improvement of health services in its immediate vicinity, Mount Sinai is cooperating with existing services to form a community health network to meet the health needs of children from three distinct age groups. Mount Sinai will help to broaden the services of five city-run child health stations to serve children in the pre-school years. A program of school health services is being designed for the five-through-twelve group, using a school health team which screens pupils for health and learning problems, arranges for follow-up care, and counsels parents and teachers. Two new pilot health services are being studied to meet the special needs of the adolescent population.

The quality of health care

There is a well recognized need for more sensitive ways of measuring the quality of health services and medical care practices, and for physicians with new skills who can improve the organization and management of programs for monitoring or delivering care. In 1973, the Foundation supported projects to increase the sources of leadership available to direct health care systems, to assess the effectiveness of medical procedures, and to encourage the individual to maintain his health. A few of these projects are described below.

Developing leadership for new roles in health

Under The Robert Wood Johnson Foundation Clinical Scholars Program, participating medical schools have developed training programs to enable skilled young physicians already trained as clinicians to acquire new educational skills in non-biological disciplines which will allow them to be more involved in the improvement of the health care system. In this program, young physicians are receiving training in economics, epidemiology, statistics, the behavioral sciences, law, and the management sciences, while continuing their post-graduate clinical experience. It is expected that Clinical Scholars will develop efficiency and recognition in these areas comparable to that of non-physicians. They are thus analogous

to the physician-biochemist or physician-microbiologist, whose scientific capabilities are recognized to be of high caliber by biochemists and microbiologists. This program builds upon an experiment started three years ago by the departments of medicine at five medical schools.

In 1973, a national program was launched to permit additional institutions to develop graduate-level programs with this focus. A board of directors was established by the Foundation, and applications from medical schools were invited. Dr. John C. Beck, chairman of the department of medicine of the Faculty of Medicine at McGill University, was appointed full-time executive director of the new program, and administrative offices were established at the University of California at San Francisco.

Seventy medical schools indicated an interest in submitting proposals for Clinical Scholar training programs, and 20 of these were invited to submit detailed accounts for the programs they planned to implement. Seven programs were selected from among these 20 to receive three-year grants starting in the 1974-75 academic year. Because of this impressive start, several additional schools will be selected for the site of new Clinical Scholar programs in 1974.

Developing better indices for the assessment of care

A new measurement technique which can provide a statistical profile of a community's health care services is being developed by Dr. David Kessner at Georgetown University in Washington, D.C. Called the "tracer method," it uses common disease entities, such as hypertension, iron-deficiency anemia, or middle ear infections as indications of the kind of medical care a selected population has received. By examining a randomly selected group of patients being treated for these conditions, a measure of the quality of diagnostic, treatment, and follow-up medical care rendered can be provided. With Foundation support, the tracer method will be tested as a tool, with the hope that it will find practical application in many communities as a guide to necessary services.

The Harvard School of Public Health received a grant to begin a program to evaluate the effectiveness and safety of various medical procedures, to identify alternative treatments, to assess the known benefits of each approach relative to cost, and to provide information on the effectiveness of specific medical care procedures.

Educating the users of health services

As part of its program to improve the qualitative aspects of health, the Foundation has also examined the increasing evidence that life styles and health are closely related and that the individual has more control over his health than he may realize. Accordingly, in 1973, grants were awarded to the Boy Scouts of America and the Boys' Clubs of America to plan programs aimed at improving health behavior for young people. In addition, the Foundation supported plans developed by the Children's Television Workshop in New York to produce a series of hour-long programs on health care for young adults.

In producing "Sesame Street" and "The Electric Company," CTW has shown that television can be effectively used to educate young people. The health series, to be carried by the Public Broadcasting Service in 1974, will be shown in the early evening and will employ a variety of communications techniques. Four major themes will be stressed in the program: basic prevention and health maintenance; finding appropriate care and making better use of the health care system; community and environmental effects on home health; and ways of financing health care. CTW will also assist communities in developing local projects on health services.

Public policy issues in health

Improving health policy planning and leadership

The need for facts and capabilities to improve analytic evaluation of public policy issues in health is a third area of interest to the Foundation. Three approaches to strengthen the nation's capacity for research and training, and to develop more resources involved in analyzing and providing information about health policy, received attention in 1973.

First, funds were awarded to establish a health policy center at the University of California at San Francisco, and to enable research groups at the University of Michigan, Columbia University, and Harvard University to review the effectiveness of governmental programs and actions aimed at improving health manpower supply and utilization.

The health policy center at San Francisco will serve as a technical agency to help government officials, educators, and health professionals with specific policy problems; will train scholars in medicine, law, and political science in health policy analysis; and will develop information on health affairs and policy issues for use by the public.

Second, The Robert Wood Johnson Foundation Fellowships in Health Policy Program was established to provide health professionals from academic centers an opportunity to develop a greater understanding of government decision-making processes in health and to assist those who may desire a future career in government to prepare for such service. The program was developed in conjunction with the National Academy of Sciences' Institute of Medicine (IOM) and the American Political Science Association. The fellowship program was initiated under the direction of Dr. Robert Q. Marston, former director of the National Institutes of Health, and a Distinguished Fellow of the IOM.

The first fellowship period will begin in September, 1974, with a series of introductory seminars designed to familiarize the fellows with the federal health agencies, Congressional committees responsible for health affairs, and the options in health policy as viewed by representatives of various governmental agencies. Following the orientation, the fellows will serve as staff officers to cooperating members of Congress.

The Foundation's third approach in the health policy field developed in response to the increasing need for state and local agencies to develop more capabilities for dealing with critical issues in health. The Citizens Conference on State Legislatures (CCSL) has initiated a program to strengthen the operation of a number of state legislative health committees by enabling them to hire professionally qualified staff personnel. Under the program, the state legislatures of Connecticut, Louisiana, Michigan, Minnesota, New Jersey, Texas, Wyoming, and Washington will be provided with two CCSL-trained staff members to assist committees working on health-related legislation. One of the professional staff members will be a health specialist; the other will be skilled in legislative procedures. Participating states were selected by CCSL and a national advisory board. Former Illinois Governor Richard B. Ogilvie is chairman of the advisory board.

Studies related to Foundation objectives

The Foundation has commissioned a series of information studies on problems related to the Foundation's objectives described in previous sections of this report. These projects are designed to provide an understanding of the background of a specific issue, previous attempts to deal with it, and alternatives for future action.

Among the issues being examined, a team of investigators from three universities is

examining the conditions which influence the availability of ambulatory care in American communities. The study, based at the University of California at Los Angeles, will review the major public and private programs which have attempted to increase access to care, such as recruiting and placing physicians in rural practice, the encouragement of group practice, and the use of nurse practitioners. How and why such changes have worked or failed to work to correct current deficiencies will be identified and the reasons evaluated.

A second research group at the University of Southern California will examine the kinds of factors which determine a physician's choice of geographic location and type of practice.

In a third study, the University of Chicago's Center for Health Administration Studies is developing ways of assessing the specific problems people face in securing medical assistance. The study will be similar to studies used to measure changes in the nation's employment pattern.

Evaluation of Foundation programs

In 1973, the Foundation supported the development of independent assessments of several projects it has initiated.

The Foundation's national program to develop regional emergency medical response systems will receive a three-year study by the Rand Corporation in Santa Monica, California. The study will focus on a selected sample of regions before and after the Foundation-supported improvements in each region are operational. These data will be supplemented by on-site observations made in the sample regions by the project's principal investigators. The report of the Rand evaluation will be given wide distribution in order to make maximum use of the results for subsequent improvements in the nation's emergency care system.

The National Planning Association in Washington, D.C., will evaluate the effects of student-aid programs on changing the mix of students enrolled in medical and dental schools, particularly the Foundation's own $14 million student-aid program initiated in 1972. The Foundation's program was designed to increase the number of women, students from rural, and minority backgrounds enrolled in the nation's medical and dental schools, in the hope that this would subsequently alter the geographic distribution of medical and dental practitioners. Its effectiveness will be determined by this independent research organization.

The Educational Testing Service, Inc., of Princeton, New Jersey, will evaluate the effectiveness of the Foundation's program to train dentists in the care of the severely handicapped, including an assessment of the extent of attitudinal change on the part of students, faculty, and the profession in terms of accepting the handicapped as patients.

A team of researchers from Georgetown University in Washington, D.C., will evaluate the program of the Citizens Conference on State Legislatures to provide state legislative committees with full-time staff in the health policy field. The objective is to document what professional staffing does to the quality of legislative decisions in the health field.

Foundation operations

Foundation operations

During 1973, the staff of The Robert Wood Johnson Foundation expanded from 38 to 52 people. There were a number of additions to the professional staff.

John C. Beck, M.D., joined the Foundation staff as executive director of The Robert Wood Johnson Clinical Scholars Program. The Clinical Scholars Program offices are based at the University of California, San Francisco. A distinguished medical educator, scientist, and clinician, Dr. Beck was chairman of the department of medicine in the Faculty of Medicine at McGill University in Montreal, Quebec, Canada, prior to joining the Foundation. He has served as chairman of the American Board of Internal Medicine and as secretary-general of the International Society of Endocrinology. A former Markle Scholar, he holds membership in a number of scientific societies, including the American College of Physicians, the American Society for Clinical Investigation, the Association of American Physicians, and the Royal Society of Medicine.

David L. Cusic and Christine M. Grant have assumed program responsibilities as executive assistants. Mr. Cusic is a University of Florida graduate who received his master's of public health from the University of North Carolina. Prior to joining the Foundation he was executive director of the Alabama Health Study Commission, after serving as associate director for planning and program development for the Alabama Regional Medical Program. Ms. Grant is a Swarthmore College graduate who received her master's of business administration in health care administration and health care financing from the Wharton School of the University of Pennsylvania. She previously had worked on health legislation in Washington, D.C., and was associated with the New York City Department of Health.

During 1973, the Foundation adopted a policy of developing a small cadre of senior program consultants who retain university affiliations while assisting in the development of program areas and devoting a substantial amount of their time to affairs of the Foundation. Four senior consultants joined the Foundation in this capacity this year.

Richard A. Berman, an assistant dean of the Cornell Medical College in New York City and associate director for ambulatory programs at the New York Hospital, is a senior consultant assisting the Foundation in the organization and management of health care service programs. Mr. Berman is a graduate of the University

of Michigan and has master's degrees in business administration and hospital administration. Prior to his Cornell appointment, he served with the Department of Health, Education and Welfare in Washington, D.C., and more recently with the health policy development unit of the Cost of Living Council.

Ann A. Bliss, an assistant professor in the department of surgery at Yale University School of Medicine in New Haven, Connecticut, is a senior consultant assisting in the development of the Foundation's programs in primary care, particularly those involving non-physician practitioners. Mrs. Bliss is a psychiatric social worker with extensive clinical nursing experience. She has a degree in nursing and a master's degree in social service from the Bryn Mawr College School of Social Research. Mrs. Bliss previously taught in the nursing programs at the State University of New York at Buffalo and at Niagara University, and is a co-author, with Alfred and Blair Sadler, of "The Physician's Assistant—Today and Tomorrow."

Robert H. Kalinowski, M.D., professor of anesthesiology at Georgetown University in Washington, D.C., is a senior consultant assisting the Foundation in the development of university-related primary care service and training programs. Prior to his Georgetown appointment, Dr. Kalinowski served as chief medical officer of the Peace Corps in the Philippines, as deputy director of the Office of Health Affairs of the Office of Economic Opportunity, and most recently as director of the division of health services of the Association of American Medical Colleges.

Donald L. Madison, M.D., associate professor of medical care organization in the department of family medicine at the University of North Carolina at Chapel Hill, is a senior consultant assisting the Foundation in the development of rural health care programs. Prior to this appointment, Dr. Madison successively served as faculty director of the student health project of the South Bronx, as director of the Appalachian health program of the Public Health Service, and finally as chief of the comprehensive health care systems branch of the Health Services and Mental Health Administration of the Department of Health, Education and Welfare, before assuming his present position at Chapel Hill in 1970.

Philip Gallagher, who heads the Foundation's library, taught in the public schools prior to completing his studies in library science. He succeeds Rubie Baysinger, who is pursuing a teaching career. Mae Lani Sanjek, a research assistant, left in August to become a nursing student at the Herbert H. Lehman College in New York City.

During the year, the Board of Trustees met six times in Princeton, New Jersey, with the regular annual meeting convened in March. Various committees of the Board also met regularly throughout the year.

Stuart Carothers
Secretary

Financial statements

During 1973, the Board of Trustees approved grants totaling $52,953,437. Federal excise taxes for 1973 amounted to $741,262 on income and $816,909 on capital gains, for a total of $1,558,171.

The grant history of the Foundation since its inception in 1936 is as follows:

Total grants, 1936 through 1971	$ 16,097,947
1972 Grants	35,713,974
1973 Grants	52,953,437
	$104,765,358

The Board of Trustees authorized during 1973 the transfer of $51,612,500 from the fixed-income securities portfolio to an equity portfolio which is externally managed. A review of performance is made quarterly.

At January 1, 1973, the Foundation held 9,949,215 shares of Johnson & Johnson common stock. During the year, 399,240 shares were sold or exchanged for other common stocks leaving a balance in the portfolio of 9,549,975 shares at December 31, 1973.

William R. Walsh, Jr.
Treasurer

Opinion of Independent 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, 1973 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, 1972.

In our opinion, the aforementioned financial statements present fairly the financial position of The Robert Wood Johnson Foundation at December 31, 1973 and 1972, 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

Trenton, New Jersey
January 25, 1974

The Robert Wood Johnson Foundation
Statement of Assets,
Liabilities and Foundation Principal
at December 31, 1973 and 1972

	1973	1972
Assets		
Cash	$ 461,801	$ 325,628
Securities (at cost, or market value on dates of gifts) (Note 2):		
Johnson & Johnson common stock 9,549,975 shares in 1973; 9,949,215 shares in 1972 (quoted market value $1,076,759,681 and $1,295,885,250)	273,765,928	282,069,139
Other corporate common stocks (quoted market value $52,405,188 and $39,781,250)	62,593,857	27,120,300
Fixed income securities (quoted market value $172,137,415 and $174,176,880)	175,818,059	174,355,755
Other assets	183,459	103,469
	$512,823,104	$483,974,291
Liabilities and Foundation Principal		
Liabilities:		
Unpaid grants (Note 1)	$ 52,397,579	$ 19,519,133
Drafts payable—grants	451,703	993,492
Federal excise tax payable	1,558,171	4,029,817
Total liabilities	54,407,453	24,542,442
Foundation Principal:		
Appropriated for 1972 payout requirement		531,404
Unappropriated balance	458,415,651	458,900,445
Total Foundation Principal	458,415,651	459,431,849
	$512,823,104	$483,974,291

See notes to financial statements, page 52.

The Robert Wood Johnson Foundation
Statement of Investment Income,
Expenses, Grants and Changes in Foundation Principal
for the years ended December 31, 1973 and 1972

	1973	1972
Investment income:		
Dividends	$ 6,945,099	$ 5,479,432
Interest	11,786,688	5,031,541
	18,731,787	10,510,973
Less direct investment expenses and Federal excise tax	901,295	485,044
	17,830,492	10,025,929
Expenses:		
Salaries, employee benefits and payroll taxes	860,958	475,895
Professional services	324,750	120,163
Rent and leasehold improvements	124,583	130,587
Meeting and travel expenses	106,896	43,863
Other administrative expenses	232,180	162,078
	1,649,367	932,586
Income available for grants	16,181,125	9,093,343
Grants	52,953,437	44,038,974
Excess of expenses and grants over investment income	(36,772,312)	(34,945,631)
Additions to Foundation Principal:		
Net capital gains on sales of securities (Note 3)	36,024,009	190,546,898
Less related Federal excise tax	816,909	3,613,315
	35,207,100	186,933,583
Contributions received:		
Trusts	546,651	302,713
Individuals	2,363	1,525
	35,756,114	187,237,821
Net (decrease) increase in Foundation Principal	(1,016,198)	152,292,190
Foundation Principal at beginning of year	459,431,849	307,139,659
Foundation Principal at end of year	$458,415,651	$459,431,849

See notes to financial statements, page 52.

1. Summary of significant accounting policies:

   Grants
   In the year grant requests are approved by the Board of Trustees, they are recorded in the accounts as unpaid grants. The unpaid grants at December 31, 1973 consist of $12,131,860 unpaid 1972 grants and $40,265,719 unpaid 1973 grants.

   Interest income
   Interest income is recorded on the cash basis. At December 31, 1973 and 1972, the amounts of unrecorded interest income were approximately $3,900,000 and $2,500,000 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, 1973 and 1972 were as follows:

	1973	1972
Johnson & Johnson common stock	$37,450,638	$190,308,969
Other securities, net	(1,426,629)	237,929
	$36,024,009	$190,546,898

4. The Foundation has a non-contributory insured pension plan covering all eligible employees. Pension expense approximated $78,600 in 1973 and $42,000 in 1972.

The Robert Wood Johnson Foundation
Other corporate common stocks
at December 31, 1973

	Shares	Cost	Quoted market value
AMP Incorporated	4,000	$ 154,357	$ 155,500
American District Telegraph Co.	6,000	272,284	237,000
American Home Products Corp.	17,000	724,829	682,125
American International Group, Inc.	4,400	346,850	330,000
Arizona Bank	4,000	137,250	140,000
Avon Products, Inc.	2,000	246,497	127,500
Barnett Banks of Florida, Inc.	3,500	191,125	158,375
Burnup & Sims Inc.	15,000	346,162	363,750
Burroughs Corporation	4,000	911,874	833,500
Central Telephone & Utilities Corp.	18,000	407,767	405,000
Citizens & Southern Corp.	6,000	163,900	151,500
The Coca-Cola Company	3,000	415,009	379,500
Walt Disney Productions	5,000	449,815	236,250
Dow Chemical Company	6,000	308,956	345,000
Dun & Bradstreet Companies, Inc.	8,000	310,280	258,000
Eastman Kodak Company	10,000	1,269,629	1,160,000
Economics Laboratory Inc.	14,000	528,250	554,750
Emerson Electric Co.	12,000	515,362	522,000
Emery Air Freight Corp.	200	10,761	11,975
Equitable Bancorporation	3,500	169,325	155,750
Exxon Corp.	4,000	377,564	376,500
Farmers New World Life Insurance Co.	4,000	238,000	236,000
First At Orlando Corp.	5,000	176,375	156,250
First International Bancshares, Inc.	3,000	145,678	173,250
First National City Corp.	20,000	835,939	915,000
Ford Motor Company	500,000	27,120,300	20,250,000
Gannett Co., Inc.	14,000	516,694	448,000
General Mills, Inc.	15,000	888,429	825,000
General Reinsurance Corp.	1,800	369,600	367,200
Goodyear Tire & Rubber Company	25,000	354,972	381,250
W. W. Grainger, Inc.	14,000	466,192	484,750
Hercules Incorporated	20,000	697,845	690,000
International Business Machines Corp.	12,250	3,857,782	3,022,688
International Flavors & Fragrances	4,000	338,764	319,500
International Paper Company	5,000	226,942	260,000
Kennecott Copper Corporation	14,000	458,497	619,500

	Shares	Cost	Quoted market value
Knight Newspapers, Inc.	10,000	$ 392,710	$ 248,750
S. S. Kresge Co.	28,000	1,020,370	917,000
Lubrizol Corp.	12,000	527,327	447,000
MGIC Investment Corp.	18,000	954,678	591,750
Masonite Corp.	22,900	526,334	709,900
Mobil Oil Corporation	20,000	1,332,132	1,060,000
Motorola, Inc.	10,000	533,662	492,500
National Starch & Chemical Corp.	8,000	451,142	440,000
A. C. Nielsen Co. (A, nonvoting)	10,000	311,212	283,750
J. C. Penney Company, Inc.	12,000	984,807	861,000
PepsiCo, Inc.	8,000	663,932	555,000
Phelps Dodge Corporation	12,000	562,502	564,000
Polaroid Corporation	10,000	1,233,156	698,750
Procter & Gamble Company	5,000	501,009	460,000
Puritan-Bennett Corp.	2,000	125,025	122,500
Ralston Purina Company	15,000	591,273	622,500
Reynolds and Reynolds Co. (A)	12,000	507,750	375,000
Roadway Express, Inc.	12,000	379,000	453,000
Schering-Plough Corp.	9,000	692,131	639,000
Schlumberger Ltd.	7,000	662,817	923,125
Sears, Roebuck and Co.	10,000	981,501	802,500
Standard Oil Company (Indiana)	10,000	926,875	1,037,500
Texaco Inc.	45,000	1,578,807	1,321,875
Wal-Mart Stores, Inc.	25,000	432,976	334,375
Weyerhaeuser Co.	8,000	293,269	313,000
Xerox Corp.	2,200	311,292	270,050
Zions Utah Bancorporation	6,000	166,313	129,000
		$62,593,857	$52,405,188

The Robert Wood Johnson Foundation
Fixed income securities
at December 31, 1973

	Face amount	Cost	Quoted market value
U.S. Government obligations:			
Bills due 9-24-74	$ 10,000,000	$ 9,179,300	$ 9,468,000
Bank certificates of deposit:			
Chase Manhattan Bank			
10.52% due 3-4-74	10,000,000	10,000,953	10,011,938
First National Bank of Boston			
10% due 6-3-74	4,000,000	4,000,548	4,018,302
10% due 6-14-74	5,000,000	5,000,693	5,024,872
9.52% due 9-10-74	15,000,000	15,002,807	15,088,269
First National Bank of Chicago			
9.76% due 1-2-74	4,500,000	4,500,000	4,499,910
10% due 1-23-74	2,750,000	2,750,125	2,749,952
Security Pacific National Bank of Los Angeles			
10.6% due 2-20-74	5,000,000	4,996,447	5,003,211
	46,250,000	46,251,573	46,396,454
Other bonds and notes:			
Associates Corporation of North America			
9.85% notes due 1-10-74	3,857,000	3,857,000	3,857,000
Bancamerica Corp.			
6⅝% notes due 2-1-80	3,000,000	2,986,800	2,865,000
Beneficial Corp.			
6¾% debentures due 7-15-79	2,000,000	2,000,000	1,915,000
7½% debentures due 7-15-02	3,000,000	2,982,000	2,850,000
Chemical New York Corp.			
6⅝% notes due 4-15-80	3,000,000	2,982,900	2,850,000
Chesapeake & Potomac Telephone Co. of Virginia			
6½% notes due 6-1-78	3,000,000	3,000,000	2,850,000
7¼% debentures due 6-1-12	2,000,000	1,977,500	1,800,000
Commercial Credit Co.			
6⅞% notes due 7-15-79	3,000,000	2,985,000	2,827,500
Consolidated Natural Gas Co.			
7⅝% debentures due 5-1-97	3,000,000	3,036,930	2,850,000

	Face amount	Cost	Quoted market value
Consumers Power Co.			
7½% first mortgage bonds due 6-1-02	$ 3,000,000	$ 3,018,750	$ 2,857,500
Dow Chemical Co.			
7.40% debentures due 7-15-02	2,000,000	2,000,000	1,900,000
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	5,000,000	5,000,000	5,262,500
Farmers Home Administration			
6.45% insured notes, series K due 6-30-77	4,995,539	4,978,054	4,783,228
6.55% insured notes, series M due 12-29-77	2,002,756	2,002,756	1,915,136
Federal Home Loan Banks			
7.80% consolidated bonds, series C1976 due 8-25-76	4,000,000	4,000,000	4,045,000
Federal Home Loan Mortgage Corp.			
7.15% guaranteed mortgage bonds due 5-26-82 to 97	3,000,000	3,013,125	2,775,000
Federal National Mortgage Association			
8¼% debentures due 12-10-75	3,500,000	3,500,000	3,556,875
7.55% debentures, series SM1977H due 12-12-77	2,000,000	2,000,000	2,020,000
7.05% debentures, series SM1992B due 6-10-92	5,000,000	5,000,094	4,643,750
Ford Motor Credit Company			
Demand notes	66,000	66,000	66,000
General Electric Credit Corp.			
6⅝% notes due 8-15-77	5,000,000	5,000,000	4,800,000
General Motors Acceptance Corp.			
6⅜% notes due 5-13-74	1,000,000	1,000,000	1,000,000
General Telephone Co. of Florida			
7½% first mortgage bonds due 8-1-02	1,000,000	990,570	930,000
Walter E. Heller & Company			
9.80% notes due 1-17-74	4,593,000	4,593,000	4,593,000
9.80% notes due 1-25-74	3,000,000	3,000,000	3,000,000
Household Finance Corp.			
7½% debentures, series IF due 8-1-95	3,000,000	3,000,000	2,865,000
Leased Tankers Inc.			
6⅝% secured notes, series A due 12-1-74	1,400,000	1,400,000	1,400,000

	Face amount	Cost	Quoted market value
Michigan Consolidated Gas Co.			
7⅝% first mortgage bonds due 7-1-97	$ 2,000,000	$ 1,978,125	$ 1,900,000
Mountain States Telephone & Telegraph Co.			
7¾% debentures due 6-1-13	2,000,000	2,000,000	1,952,500
Northern Illinois Gas Co.			
7⅝% first mortgage bonds due 7-1-97	2,000,000	2,005,540	1,920,000
Northwestern Bell Telephone Co.			
7½% debentures due 4-1-05	3,000,000	3,042,500	2,880,000
Pacific Gas & Electric Co.			
7½% first and refunding mortgage bonds, series YY due 6-1-04	3,000,000	3,000,000	2,853,750
Southern Bell Telephone & Telegraph Co.			
6½% notes due 7-15-79	2,000,000	1,987,500	1,900,000
7⅜% debentures due 7-15-10	3,000,000	2,952,500	2,745,000
Southern California Edison Co.			
7⅜% first and refunding mortgage bonds, series BB due 8-15-97	1,000,000	997,170	940,000
Southwestern Bell Telephone Co.			
6½% notes due 5-1-79	3,000,000	2,976,250	2,846,250
7⅜% debentures due 5-1-12	3,000,000	2,990,400	2,790,000
Tennessee Valley Authority			
7.35% power bonds, series C due 7-1-97	4,000,000	4,000,000	3,780,000
Textron Inc.			
7½% sinking fund debentures due 7-15-97	2,000,000	2,000,000	1,900,000
Toledo Edison Co.			
7½% first mortgage bonds due 8-1-02	2,000,000	1,995,000	1,840,000
Twelve Federal Land Banks			
6.80% consolidated loan bonds due 10-23-79	4,000,000	4,063,750	3,920,000
	120,414,295	120,359,214	116,244,989
Purchased interest	27,972	27,972	27,972
	$176,692,267	$175,818,059	$172,137,415

The Robert Wood Johnson Foundation
Summary of Grants
for the year ended December 31, 1973

Alderson-Broaddus College
Philippi, West Virginia

Physicians assistants program in primary care

American Arbitration Association
New York, New York

Evaluation of the role of conflict prevention and resolution procedures

American Association for Comprehensive Health Planning
Alexandria, Virginia

Technical assistance for health planning agencies

American Association of Colleges of Pharmacy
Silver Spring, Maryland

Study of the education of pharmacists

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

Study of health professions education

American Board of Medical Specialties
Evanston, Illinois

Problems of judging professional competence

American College of Surgeons and American Surgical Association

Joint study of surgical services in the United States

University of California, San Diego, School of Medicine
La Jolla, California

Harvard Medical School
Boston, Massachusetts

Johns Hopkins University, School of Medicine
Baltimore, Maryland

Grants awarded in 1973 appear in color. Those awarded in prior years appear in black. The original amount of a grant awarded in a prior year appears in brackets following the grant description. Those grants with an asterisk (*) are local projects in the New Brunswick, New Jersey Area where the Foundation maintains an historic and continuing interest beyond the national program objectives.

Unpaid grants January 1, 1973	1973 grants authorized	1973 payments	Unpaid grants December 31, 1973
$	$ 693,000	$ 217,865	$ 475,135
	25,000	25,000	
	200,000	100,000	100,000
	35,000	35,000	
	185,000	185,000	
	15,425	15,425	
	15,326	15,326	
	49,500	49,500	
	66,747		66,747

American College of Surgeons and American Surgical Association
(continued from page 58)

University of Michigan Medical School
Ann Arbor, Michigan

Washington University, School of Medicine
St. Louis, Missouri

American Fund for Dental Education
Chicago, Illinois

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

Administration of the Foundation's program to train dentists in the care of the handicapped

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American Society of Contemporary Medicine and Surgery
Chicago, Illinois

Planning a physicians' telephone consultation service

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 management capabilities of academic medical centers
[$316,440 authorized in 1972]

Distribution of a physician recruitment film

Association of Physician Assistant Programs
Washington, D.C.

Program with the American Academy of Physicians Assistants to foster training of new health practitioners

---

Baylor College of Medicine
Houston, Texas

Preparation of physicians in primary care

Bethany Brethren — Garfield Park Community Hospital
(formerly Bethany Brethren Hospital)
Chicago, Illinois

Planning for an ambulatory care system

Unpaid grants January 1, 1973	1973 grants authorized	1973 payments	Unpaid grants December 31, 1973
$	$ 86,400	$ 43,200	$ 43,200
	52,027	52,027	
30,000		10,000	20,000
	150,000	50,000	100,000
	25,000	25,000	
30,000		10,000	20,000
169,220		169,220	
	25,000	25,000	
	123,473	60,000	63,473
	240,000	80,000	160,000
	54,000	54,000	

Boston University, School of Medicine
Boston, Massachusetts

Feasibility of a health policy research center

Boy Scouts of America
North Brunswick, New Jersey

National program of health education

Boys' Clubs of America
New York, New York

Planning a health education program

The Brookings Institution
Washington, D.C.

Study on 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

University of California, Los Angeles, School of Medicine
Los Angeles, California

Research and writing project on access to care in U.S. communities

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

Establishment of a health policy center

Evaluation of the Medical College of Virginia curriculum

University of Chicago
Chicago, Illinois

Development of a national index to measure access to physician care

Unpaid grants January 1, 1973	1973 grants authorized	1973 payments	Unpaid grants December 31, 1973
$	$ 30,288	$ 30,288	$
	144,000	72,000	72,000
	24,791	24,791	
59,600			59,600
200,000		145,194	54,806
155,000		30,597	124,403
	1,178,000	387,860	790,140
	129,000	129,000	
	1,200,000	400,000	800,000
	10,000	10,000	
	61,000	61,000	

Children's Television Workshop
New York, New York
Planning and production of a national television program on health

Citizens Conference on State Legislatures
Kansas City, Missouri
Program to strengthen the role of state legislatures in health

Clinical Scholars Program
National program to prepare young physicians for leadership roles in medical care
[$5,900,000 authorized in 1972]
(See Schedule A, page 84)

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

Columbia University
New York, New York
Public policy program in health services and manpower

Columbia University, Center for Community Health Systems
New York, New York
Research and writing on the design and development of hospital ambulatory care programs

Columbia University, College of Physicians and Surgeons
New York, New York
Planning for a child health care system

Committee for Economic Development
New York, New York
Distribution of a report on U.S. health care organization and financing

Community Health Care Center Plan, Inc.
New Haven, Connecticut
Development of primary care prepaid group practice program
[$350,000 authorized in 1972]

Unpaid grants January 1, 1973	1973 grants authorized	1973 payments	Unpaid grants December 31, 1973
$	$ 1,700,000	$ 200,000	$ 1,500,000
	1,996,000	584,850	1,411,150
5,900,000	748,381	504,847	6,143,534
408,588			408,588
	519,000	161,400	357,600
	222,000	74,000	148,000
	377,000	377,000	
	146,000	146,000	
	20,000	20,000	
150,000		150,000	

Cornell University Medical College
New York, New York

Planning for ambulatory care

Design for a comprehensive study of the source and structure of medical values

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Cottonwood Health Group, Inc.
Tekamah, Nebraska

Development of a community health center

Council on Foundations
New York, New York

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

Dental Student Aid Program[1]
Grants to dental schools for scholarships and loans
[$4,000,000 authorized in 1972]

University of Colorado, School of Dentistry
Denver, Colorado

State University of New York at Stony Brook, School of Dental Medicine
Stony Brook, New York

Dental Training Program[2]

Grants to dental schools to train dentists in the care of the handicapped

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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 non-profit rural group practice

Educational Facilities Laboratory, Inc.
New York, New York

Study of ambulatory health facilities

Unpaid grants January 1, 1973	1973 grants authorized	1973 payments	Unpaid grants December 31, 1973
$	$ 499,000	$ 339,000	$ 160,000
	25,000	25,000	
	209,000	121,444	87,556
40,000			40,000
4,000,000		4,000,000	
	21,410	21,410	
	21,410	21,410	
	4,700,000		4,700,000
768,896			768,896
	400,000	200,000	200,000
	25,000	25,000	

Educational Testing Service
Princeton, New Jersey
Planning project to develop an evaluation of dental training programs

Emergency Medical Response Program[2]
Grants to communities developing regional systems

Evanston Medical Consumers
Evanston, Illinois
Development of a non-profit group practice

University of Florida, College of Medicine
Gainesville, Florida
Development of primary care health services

Forsyth Dental Center
Boston, Massachusetts
Evaluation of dental hygienists' role in primary dental care

Genesee Hospital
Rochester, New York
Expansion of an ambulatory care program

George Washington University
Washington, D.C.
Evaluation of the Health Staff Seminar Program

George Washington University, School of Medicine
Program in primary care

Georgetown University
Washington, D.C.
Evaluation of programs to strengthen the role of state legislatures in health

Georgetown University, School of Medicine
Development of primary care prepaid group practice program
[$196,000 authorized in 1972]
Planning and program to improve methods for evaluating the quality of health care services

Glenville Health Association
Cleveland, Ohio
Development of a non-profit group practice

Unpaid grants January 1, 1973	1973 grants authorized	1973 payments	Unpaid grants December 31, 1973
$	$ 3,150	$ 3,150	$
	15,000,000		15,000,000
	188,000	88,000	100,000
	183,000	31,200	151,800
	300,000	300,000	
	187,000	76,709	110,291
	17,500	17,500	
	600,000	200,000	400,000
	233,300	72,965	160,335
56,000		56,000	
	626,119	251,334	374,785
	400,000		400,000

The Greater Hartford Process
Hartford, Connecticut

Development of primary care programs

Hamilton Park Youth Development*
Somerset, New Jersey

Expansion of a community center

Harvard Community Health Plan, Inc.
Boston, Massachusetts

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

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 for primary medical care

Harvard University, School of Public Health
Cambridge, Massachusetts

Studies of the effectiveness of selected medical procedures

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

Research and writing on child health and ambulatory health care standards

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Harvard University, Department of Economics
Cambridge, Massachusetts

Health economics training program

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

Program in health services development

Health Care Management Systems, Inc.
Denver, Colorado

Research on computer applications in ambulatory health services

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Unpaid grants January 1, 1973	1973 grants authorized	1973 payments	Unpaid grants December 31, 1973
$	$ 147,000	$ 147,000	$
	25,000	25,000	
446,106		396,676	49,430
111,500			111,500
	337,644		337,644
	750,000	250,000	500,000
	500,000	50,000	450,000
	423,000	134,400	288,600
	375,000		375,000
	62,000	62,000	

Hospital Research and Educational Trust of New Jersey
Princeton, New Jersey
Feasibility study of computer-based hospital cost analysis and control system
[$60,000 authorized in 1972]

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

Institute of Society, Ethics and the Life Sciences
Hastings-on-the-Hudson, New York
Study of the role of ethical values in health

Johns Hopkins University
Baltimore, Maryland
School of health services training program

Lawrence County Hospital Association
Moulton, Alabama
Evaluation of a Medex Program

Maine Medical Center
Portland, Maine
Community service and teaching program in primary care

The Martinez Health Center, Inc.
Martinez, California
Development of primary care prepaid group practice program
[$350,000 authorized in 1972]

Massachusetts Institute of Technology, Alfred P. Sloan School of Management
Cambridge, Massachusetts
Staff training systems for health care institutions
[$257,929 authorized in 1972]

The Matheny School*
Peapack, New Jersey
Equipment support

The Matthew Thornton Health Plan, Inc.
Nashua, New Hampshire
Development of a non-profit group practice

Unpaid grants January 1, 1973	1973 grants authorized	1973 payments	Unpaid grants December 31, 1973
$ 30,000	$	$ 30,000	$
440,000			440,000
	293,000	94,000	199,000
	3,000,000	500,000	2,500,000
	9,620	9,620	
	359,000	154,000	205,000
100,000			100,000
128,929		128,929	
	5,000	5,000	
	356,000	200,000	156,000

Medical Student Aid Program[1]

Grants to medical schools for scholarships and loans
[$10,000,002 authorized in 1972]

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

Study of the development of prepaid group practices

Program on health manpower development

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

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

Nursing and allied health sciences scholarship program

Middlesex General Hospital*
New Brunswick, New Jersey

Land acquisition and equipment program

Middlesex Rehabilitation Hospital*
North Brunswick, New Jersey

Equipment support

Montefiore Hospital and Medical Center
Bronx, New York

Training physicians and other professionals in team practice

Mount Sinai School of Medicine
New York, New York

Primary care services for children and youth

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

Fellowships in health policy program

Unpaid grants January 1, 1973	1973 grants authorized	1973 payments	Unpaid grants December 31, 1973
$ 492,712	$	$ 492,712	$
4,050,000		876,777	3,173,223
	25,000	25,000	
	375,000	119,253	255,747
29,950			29,950
	15,000	15,000	
	360,000	360,000	
	25,000	25,000	
	700,000	300,000	400,000
	600,000	243,000	357,000
	710,000	108,000	602,000

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

Administration of the Foundation's regional emergency medical response program

National Board of Medical Examiners
Philadelphia, Pennsylvania

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

National Bureau of Economic Research
New York, New York

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

National Health Council
New York, New York

Program to strengthen organizations and agencies working in health

National Medical Fellowships
New York, New York

Scholarships for minority medical students

National Planning Association
Washington, D.C.

Research on the impact of student aid programs

Analysis and publication of trends in federal expenditures in health

University of Nebraska Medical Center
Omaha, Nebraska

Program in primary care

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

Preprofessional summer study for minority-group students

Planning project for South Jersey mobile rural health services

Unpaid grants January 1, 1973	1973 grants authorized	1973 payments	Unpaid grants December 31, 1973
$	$ 300,000	$ 200,000	$ 100,000
83,300			83,300
150,000			150,000
	250,000	184,400	65,600
	1,000,000	500,000	500,000
	206,728	85,289	121,439
	198,548	198,548	
	503,000	129,320	373,680
666,582			666,582
	493,000	152,495	340,505
	55,000	55,000	
	25,000	25,000	

New York University Medical Center
New York, New York

Planning for an urban health program

Pittsburgh Free Clinic
Pittsburgh, Pennsylvania

Development of an educational program with the University of Pittsburgh, School of Medicine

Princeton Area United Community Fund
Princeton, New Jersey

Support for the 1972 campaign

Princeton University
Princeton, New Jersey

Minority health manpower meeting

Radcliffe College
Cambridge, Massachusetts

Preparation and placement of women in community health careers

The Rand Corporation
Santa Monica, California

Evaluation of regional emergency medical response systems

University of Rochester
Rochester, New York

Program to train physicians and nurses for general medical care

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

System of education and service in ambulatory care

St. Joseph Hospital
Albuquerque, New Mexico

Development of a rural health clinic network

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

Equipment support

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

Scholarship support

Unpaid grants January 1, 1973	1973 grants authorized	1973 payments	Unpaid grants December 31, 1973
$	$ 67,000	$ 67,000	$
	15,000	15,000	
	15,000	15,000	
	1,000	1,000	
	318,000	157,000	161,000
	462,650	213,698	248,952
	1,395,000	476,761	918,239
	434,000	94,945	339,055
	213,000	44,250	168,750
	250,000	250,000	
	24,000	24,000	

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
Los Angeles, California
Research on physician location and type of practice
Study of the role of medical specialists in primary care

Stanford University, School of Medicine
Stanford, California
Comparative study of the use of surgery by socioeconomic groups

Student American Medical Association Foundation
Rolling Meadows, Illinois
Field service in community health for health science students

Student National Medical Association
Washington, D.C.
National medical preceptorship program

Thomas Jefferson University
Philadelphia, Pennsylvania
Planning for ambulatory care

Tuskegee Institute
Tuskegee, Alabama
Planning for primary care services

United Community Services of Central Jersey*
New Brunswick, New Jersey
Support for the 1973 campaign

Utah Valley Hospital
Provo, Utah
Network of rural health clinics
[$344,840 authorized in 1972]

Unpaid grants January 1, 1973	1973 grants authorized	1973 payments	Unpaid grants December 31, 1973
$	$ 8,000	$ 8,000	$
	8,000	8,000	
	300,000	300,000	
	84,000	84,000	
	20,000	20,000	
	250,000	150,000	100,000
	83,000	43,000	40,000
	650,000	192,000	458,000
	148,000	148,000	
	100,000	100,000	
344,840		171,350	173,490

University of Vermont, College of Medicine
Burlington, Vermont

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

Washington Journalism Center
Washington, D.C.

Publication of a report on health care financing

Washington University, School of Medicine
St. Louis, Missouri

Establishment of an ambulatory care teaching practice

University of Wisconsin
Madison, Wisconsin

Research and training in the economics and sociology of health care services

Yale University, School of Medicine
New Haven, Connecticut

Research on the structure and quality of primary pediatric care

Scholarships for medical students[3]

Refunds and cancellations

[1] *A list of grant recipients under this program appeared in the 1972 report.*
[2] *A list of grant recipients under this program will appear in the 1974 report.*
[3] *This program has been replaced by the medical student aid program.*

Unpaid grants January 1, 1973	1973 grants authorized	1973 payments	Unpaid grants December 31, 1973
$ 477,910	$	$ 217,524	$ 260,386
	3,500	3,500	
	600,000	200,000	400,000
	486,000	156,100	329,900
	376,000	79,432	296,568
	9,703	9,703	
$ 19,519,133	52,989,640	20,111,194	$52,397,579
	36,203	36,203	
	$52,953,437	$20,074,991	

The Robert Wood Johnson Foundation
Summary of Grants
for the year ended December 31, 1973
Schedule A—Clinical Scholars Program

	1973 payments	Unpaid grants December 31, 1973
University of California, San Francisco, School of Medicine, and Stanford University, School of Medicine	$	$ 850,010
Case Western Reserve University, School of Medicine	48,000	876,552
Duke University, School of Medicine	96,000	121,379
Johns Hopkins University, School of Medicine	96,000	989,880
McGill University, McIntyre Medical Sciences Center	90,378	817,721
University of North Carolina, School of Medicine		726,766
University of Pennsylvania, School of Medicine		720,099
Stanford University, School of Medicine	96,000	
Yale University, School of Medicine		743,421
Administrative Costs	78,469	297,706
	$504,847	$6,143,534

Application for grants

The Robert Wood Johnson Foundation is a private philanthropy interested in improving health in the United States. During its early developmental years, it will concentrate 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, at the outset 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

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