The Robert Wood Johnson Foundation Annual Report 1972

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The Robert Wood Johnson Foundation
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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

One Foundation's Aspirations

The Robert Wood Johnson Foundation has been propelled to full growth during one of our nation's livelier periods of self-examination. We are witnessing striking changes in behavior and ways of looking at things that could not have been foretold even two decades ago. There is the feeling on the part of some that all is not well with our country, and there are marked differences in opinion about how we might better the current American climate. Yet, when the rhetoric of these conflicting voices and movements is stripped away, there is a strong theme which could become a common rallying point. This is the conviction that by the conscious and thoughtful voluntary actions of people, it is possible to better the human condition.

This conviction has been traditionally shared by those in private philanthropy. Thus, from the standpoint of public attention to the issues to which foundations devote their energies and resources, this is an ideal time to begin a program, for those who hold the belief that the quality of life can be improved through human ingenuity need encouragement and support. However, like other social institutions, foundations are being critically examined by many. Thus, they must prove to the public that private philanthropic organizations have a meaningful and important role to play in our society.

So after a relatively brief period of organization and development, the occasion of this Annual Report allows me to describe The Robert Wood Johnson Foundation's transition to a nationally oriented foundation, to share our views on the particular health scene in which we will operate, and the thinking on which our initial actions have been based.

With the settlement of the estate of the late Robert Wood Johnson in the latter part of 1971, the Foundation was launched on its current course. Because of Mr. Johnson's long-term interests in health and the improvement of medical care, the trustees directed that the Foundation's resources be used in ways which would promote the betterment of the health of the American people. To their special credit, the trustees determined to establish the Foundation as an independent philanthropy. To implement this decision the trustees sought a professional staff well-qualified in health affairs, while simultaneously refining broad program objectives and initiating a nationwide grant program. Thus, the process of building a program was begun.

At that time, the Foundation was represented by a total staff of two, housed in a former three-bedroom Victorian dwelling in New Brunswick, New Jersey, and confronted with a voluminous avalanche of incoming mail. The chairman of the board, trustees, and staff worked around a table in the living room to lay plans for organization, staffing, and bigger quarters. A shared conviction that the Foundation could play an important role in encouraging those working to improve health care in our country led to a broad outline of our initial plans for programs. Throughout the remainder of the year our major efforts have gone to refining and focusing these aspirations.

Recognizing that The Robert Wood Johnson Foundation's resources represent the largest single source of private capital to support new efforts in the health field, we sought wide counsel to help us decide where our funds might be put to work most effectively. We have studied previous foundation triumphs and failures. We have held conferences with a number of the best minds working on broad problems in health. We have had discussions with our colleagues in medicine and other health professions, and with the staffs of many of the decision makers in government who are working to develop effective

legislation in health. We have also consulted with those who are users of health services, studied much of the available literature, and looked at the economic, social, and political scene in which we will operate. And we've *contemplated*—a rare privilege in our world.

The current social scene

There are many problems in our society which weigh on the minds of Americans today, perhaps none so heavily as the apparent failure of many programs introduced during the last several decades to correct some of our most serious social problems. In the period immediately preceding and following World War II, Americans had high hopes, indeed, considerable confidence, that we could create in this country a society which could offer dignity, quality, and equity to all of our citizens. We were determined to eliminate poverty, abolish racial discrimination, eradicate substandard housing, revitalize our decaying cities, and provide equitable educational opportunities and quality health care to all.

That we have not been able to accomplish these laudable goals is abundantly evident. Thus, today we have the paradox of a country enjoying continuing economic growth and a high level of scientific achievement but in which some question its abilities for

self-renewal or its capacity to marshal its resources to meet the problems of those in need. It follows that some believe that these vexing conditions cannot be solved rationally through thoughtfully planned and reasonable social programs.

To me, this view stems from a lack of recognition of the complexities of the problems involved and a failure to understand that social issues of this sort do not lend themselves to conventional or short-term economic or political responses. They should *not* receive less of our attention; they are *different* kinds of problems requiring thoughtful new approaches, and recognition of the fact that new kinds of thinking and changes in values are required to deal with them in our pluralistic democratic structure. Their nature is well illustrated in the field of health care.

The health enterprise—elements in the equation

The present level of health in this country results from the workings of a continuously evolving, highly-complex socio-technologic system. On balance, the system has served us well but there are wide gaps between what could be done and what is being done. While some segments of our society have been most inadequately served, no part of the society today—be they the poor, middle class, or well-to-do—is without problems in readily obtaining fully satisfactory health services.

Given the size and complexity of our methods for delivering care, it seems highly unlikely that the gaps between what could be and what is in health care will be satisfactorily narrowed simply by further "natural" or unplanned evolution. Instead, if the delivery of health services to all our citizens is to be significantly improved, all of us must actively plan for change.

We need a structure in which health professionals and new kinds of health services can be better woven into the fabric of American life. For despite having built the most impressive biomedical science technology programs in the world and having trained a superb group of health professionals, we are confronted with a wholly inadequate fit between our superb medical technology and the health requirements of many of our citizens. Further, we are faced with the specter of costs escalating at alarming rates, by a moving standard in the quality of care offered in different sections of the country, by widespread evidence that some of the human caring functions of medicine are not being adequately served, and by a lack of clear, easily understood objectives which will allow development of sensible and workable long-range public policies which can improve medical care for all of us. As pressing basic national problems in health, the following seem central:

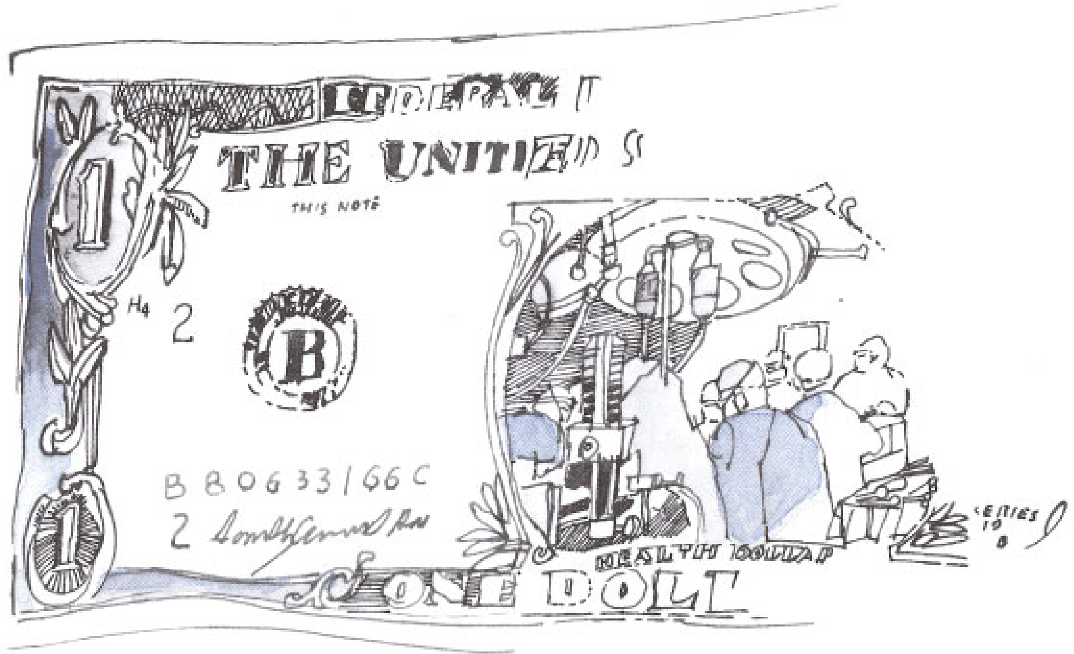
Difficulties in obtaining simple office or ambulatory medical care. The uneven availability of continuing medical care of acceptable quality is one of the most serious problems we face today. Here the problem

is two-fold. First, there are too few health resources in rural and urban poverty areas. Thus, we have too many people—particularly our poor, our elderly, and our isolated, who have greater medical needs—lacking ready access to appropriate services. Second, the specialty balance of physicians and their associated personnel is significantly out of line with needs. There is a sharp shortage of those who deliver primary care and increasing evidence to suggest a relative oversupply of physicians in certain medical and surgical specialties. In simple terms, there are not enough physicians and their associates willing and able to handle frontline, preventive run-of-the-mill complaints or emergency care, and a significant excess of certain others who offer highly specialized services.

In the period immediately following World War II, impressed with the success of organized research in furthering our war efforts, the American public approved rapidly increasing expenditures for the conduct of biomedical research. The gains in knowledge of the human condition resulting from this effort are monumental, and the number of diseases in which medical intervention can make a change for the better has been significantly enlarged. These are magnificent advances, and we should be proud of them. That they have not been transferred to the marketplace with sufficient speed, or that this has occurred too inequitably, does not lessen these achievements. However, what we failed to recognize during this era was that increased knowledge about biomedical life processes and their derangements represented only part of the task. The provision of health services of the right kind at the right time to the right person was an equally challenging need—but it was largely ignored. It needs attention now.

The escalating costs of medical care. It is the rapidly escalating costs of medical care—not health care, but medical care—which has triggered the current dissatisfaction about how the health professions function today. Further, these costs are unevenly and inequitably distributed, which is why the mass media have their tragic stories about families or individuals financially destroyed by a single major illness. The costs of basic office or clinic care also present a significant roadblock for many with marginal incomes.

The reasons for these rising costs are many. Some are understandable, justifiable, and inevitable. The rising costs of certain kinds of medical care have often been presented in highly misleading ways which do not take into account the change in the sophistication of services offered. To compare the cost of heart attack care 10 years ago with current expert care in a coronary care unit is like comparing the cost of a Model T Ford and a 727 jetliner, because both represent means of transportation! Concerns with cost, however, have moved our nation toward the culmination of a prolonged debate about how to eliminate economic barriers to obtaining medical services, and current evidence suggests that we will have some form of national financing for basic health services for all of our citizens in the near future.



Once again, however, we are at risk of believing that an overly simplistic solution will solve a very complex problem. Just as it became evident that the results of basic biomedical research were not adequately transferred from the laboratory to the field, it seems equally likely that the financing of health care will not overcome the problems of inequitable distribution, assure wise allocation, or the appropriate use of medical resources. While financial barriers are a major obstacle to care for many, available evidence suggests that the equation: Biomedical Research + Financing = Adequate Health Services, is simply not the case. Any form of national financing of health services without changes in our current ways of delivering health care will create a series of expectations for Americans which are not likely to be fulfilled.

As presently structured and organized, the nation's health services can do little to meet the increased demand which will come if a national health financing plan is adopted. The result, in all probability, will serve to escalate costs further. Also, the potential oversaturation of the medical care system may even erode quality unless we can develop a better organization of services so that all of us can have reasonable

access to those institutions and to those health professionals who have the capacity to alleviate pain, anxiety, and physical disability.

Qualitative inequities in the health system. The tools for measuring the quality of care rendered are very primitive. This is particularly the case for those services that are provided in out-of-hospital ambulatory settings. Even health professionals have difficulty in its assessment. The ability to evaluate the quality of care given becomes increasingly important as the evidence grows that if certain services were better organized, particularly those needed by children and individuals with chronic illnesses, the health of those groups would be significantly improved. Thus, there is a need for far better indices of quality, and more programs aimed at helping the public make more sophisticated choices about the care they choose to receive.

Strengthening the human caring and supportive functions of medicine. Physicians and other health professionals are often seen by their patients as being less interested or less skilled in understanding and coping with the problems of human anxiety, despair, or loneliness than is desired. While it is clear that we have developed a system which can deliver high levels of complex medical care in life-threatening illness, our health system is found wanting in many situations where understanding and personal support are important to patient comfort and healing.

Many factors have coalesced to create these dissatisfactions. We live in a society where traditional institutionalized sources for personal support are failing. Family structure, sense of community, and the church appear less capable of providing this support than in the past. Consequently, many in society look to the health professions for the kinds of human support which are less effectively offered by other societal institutions. Skills in empathy, counseling, and understanding the powerful therapy of personal caring need strengthening if we are to develop an effective system of providing humanistically oriented care. American medicine is viewed as poorly equipped to deliver these kinds of support at present.

Coordination of policy planning for health and medical care. While the framers of the Constitution were remarkably farsighted, they could not have predicted the size, range, or complexity of the roles of government or national professional institutions in the field of health. We are now living in an era when more than one-third of our health and medical expenditures come from government. In large cities, a bewildering array of different federal, state, and local programs support the provision of health services. Our academic institutions for training health professionals depend heavily on support from Washington agencies, often receiving over 50 per cent of their income from federal resources.

Despite increasing sophistication, there is general agreement that policy choices about how we design our health future are more and more difficult, and that no sector—government, professional associations,

and the public—is well equipped for this task. There is a recognized lack of facts, and of institutions, or groups capable of tackling the analysis of difficult questions about how we should plan our health affairs. As a result, many efforts to deal with broad issues in medicine and health have been found wanting.

In America, there is a marked preference for strong private institutions and pluralistic approaches to community problems. This is one of the cornerstones of our country's strength. But this also means that many people and many institutions will be involved in charting America's health future. The so-called health care industry is a loose public-private consortium of many individuals and groups, with different views of the world. Each group holds but a small piece of the mosaic which must be put together to have an integrated system. Thus, an effective, workable system which will permit care of acceptable quality to be delivered to all will require the cooperative efforts of many, and the concurrence of multiple groups and individuals who make decisions about the allocation of health services, medical care, and the dollars to cover their costs. These include local, state, and federal agencies; our schools of medicine, dentistry, nursing, and other health professions; public and private hospitals; physicians; dentists; nurses; pharmacists; insurance firms; even the courts, policemen, firemen, and private ambulance companies; and those who are the recipients of health services.

The problem with successfully undertaking national activities relating to health is the complexity of the areas in which policy must be formulated. Solutions will require knowledge of the pluralistic nature of our health system, the state of medical knowledge, the capabilities of the system, cultural patterns, behavior related to health, and the economic and legal forces involved. Clearly, ways to strengthen the quality of decision making in an area as basic as health are urgently needed.

The foundation's initial program

This list of problems we face in delivering acceptable health care to all of our citizens is by no means exhaustive. It is, however, a list of some issues which can be identified as problems of major national concern. Moreover, examination of these issues, coupled with our many discussions with those who cope with them, has strengthened our conviction that there exists in this nation the will, the wisdom, and the energies to move our society toward bettering our performance in a number of these areas. Thus, *the trustees and the staff have selected for our initial effort, the encouragement of institutions or individuals who are attempting to restructure the American health delivery system to make effective care more available for non-hospitalized patients.*

This decision has not been arrived at without considerable thought, coupled with the recognition that adoption of this focus means that we will initially devote less attention to other problems or other approaches which many feel of equal, if not more compelling, importance.

Efforts to improve this country's health might be furthered by supporting additional expansion of that body of knowledge and techniques which make it possible for illness and disease to be controlled. The methods for effecting changes in this sector are familiar. They have been admirably advanced by science and federal support during the last three decades. The scientific base upon which the practice of medicine rests, and the educational quality of professional training in the health sciences, are vital to the success of any system of health care. As a nation we must continue to give priority to basic research in biological science. Over the long haul, only more knowledge about what goes wrong to create disease will reduce the extraordinary costs of our supportive "half-way" medical technology. Thus, we now treat the ravages of heart attacks, or chronic kidney disease, or crippling arthritis, after-the-fact. Preventing such tragedies would be vastly preferable—and cheaper! It has taken our best efforts over the past 30 years to develop our biomedical science research programs, and many of us have had a deep personal commitment to the fulfillment of these goals. These programs must be supported, and for the Foundation to elect to extend these efforts would have logic and validity.

However, a review of this recent history has led us to conclude that a new foundation of our size should move in another direction—

that of improving the organizational structure and system by which we translate biomedical science knowledge into health services. And this is also difficult and has another dimension. For this direction involves changes in the values and behavior of people—those who would require health care, and those who would serve as healers. Changes of this sort come more slowly or are accepted less readily than changes in technology, and the methods by which they are effected are less clear. Be that as it may, improvements in this sector seem of vital importance and much needed at this time.

Thus, we have asked ourselves what kinds of programs and approaches might we support to achieve a more equitable distribution of medical services of acceptable quality, and how can the system be encouraged to function at a level consistent with the needs of the American public?

In addressing this basic issue, three corollary questions have emerged:

1. What changes in the organization of professionals, in the training of the next generation of health practitioners, and in the uses of our technology, will be required to improve equity in the distribution of health and medical services?

2. Can we develop standards which can assure all Americans that the care they receive is consonant with the levels of technical and human capacity currently available?

3. How can we offer decision makers at all levels the information necessary to discharge their responsibilities for improving health and medical services?

The answers to none of these questions are simple. There is a lack of knowledge about what changes in one area will do to other sectors of our system of health care. Also, as noted, potential solutions to these questions will touch on values, beliefs, and traditions deeply imbedded in American society. So, changes in how we go about our business of delivering health care will raise yet other difficult questions, but this is the nature of change, and we must learn increasingly to deal with it with comfort and confidence if we are to move forward.

Obviously, this Foundation cannot address all of the problems outlined. However, we have decided to direct our efforts and resources at the outset toward three important problems which demand both thought and action.

1. *Improving access to medical care services for underserved Americans.*

We need to better provide health services of the right kind, at the right time, to those who need it. Therefore, in its initial years, the foundation will try to identify and encourage efforts to expand and improve the delivery of primary, frontline care—particularly ambulatory care. Ambulatory care is emphasized because in a lifetime most of our medical care is obtained on an ambulatory basis. Moreover, once hospitalized, the individual has already hurdled the access barrier. Consequently, our attention has been directed toward new methods of delivering continuing family-oriented care, or experiments with new types of health professionals which may improve the availability of those kinds of services usually provided by physicians. We will also look for programs to develop a better geographic balance of health facilities and personnel to meet the needs of areas currently lacking one or both of these necessary resources. During this first year, a number of programs addressing themselves to these problems have received support.

2. *Improving the quality of health and medical care.*

To improve easy and proper access to services is largely the responsibility of the provider. However, the provision of quality requires that both providers and recipients of services change their ways of doing things. Here, our efforts will be directed toward the support of programs designed to improve the qualitative performance of the health system in its provision of technically proper treatment, appropriate human support, and all feasible preventive health services.

We are concerned not only with the gaps indicated by traditional measurements of the health of groups of our people—such as infant mortality, or life expectancy, or days lost from work or school. We also have in mind more subtle gaps which may reflect the impact that inadequate medical care can have on the quality of people's lives, such as their ability to cope with or function in a complex society when,

for example, the care required couldn't be found, the technology available wasn't used, or the information provided or the treatment rendered was not appropriate. We would like to see these aspects of health given more thoughtful attention. Thus, we will also be interested in programs or approaches which can reinforce or improve the critically important human caring functions of the health professions.

In this most difficult area of assessment of quality, we have attempted to focus on ways in which existing skills and knowledge can be applied better, and in assisting those who are working to develop more objective ways of measuring the quality of health services. Although our support of programs in this area has been less extensive because of its complexities, we feel this information will become increasingly important if this country moves to any system of national financing of health care.

We will also support a few groups who are attempting to improve the health behavior of individuals in ways which might prevent disease or decrease the load on the health system. Progress in this area of public understanding and education will require changes in human behavior so that individuals will take the necessary steps—like immunization or stopping smoking—to remove factors that might cause ill health, or make better use of what can be offered by medical care. Here there are some interesting possibilities for new uses of mass media, new behavioral science information, and new educational techniques, though they are largely untested except with the very young.

3. *Developing mechanisms for objective analysis of public policies in health.*

Lastly, we will support selected programs to improve the nation's ability to identify alternative policies in health. We recognize that planning is not a panacea, but it is the only alternative to proceeding without plans. To do this well will require more judgment than we claim to possess, for to be effective, solid objective data on the possible *outcomes* of different local or national choices must be readily available to those who are decision makers. Simply developing the evidence or information on an issue will not be enough.

We believe that better solutions can be devised by those who must make long-range decisions for our society if support is provided for the development of timely, well-targeted policy research projects which can be translated into a form usable by those who must act. Clearly, such policy research efforts must have independent financial support to avoid governmental or professional pressures. We will not be supporting many such programs, electing to move slowly and select a few at any one time to see if such efforts bear fruit.

Some of our initial awards in these three areas are described in the following section of this report. While only time will determine the significance of our early efforts, we believe they are vigorous, basic approaches designed to improve the availability of care.

In detailing these areas of initial focus for The Robert Wood Johnson Foundation, we clearly recognize that even the early attainment of our objectives would not solve a number of the major health problems of America today. Excluded from this account of problems which face us in health and of the Foundation's program emphasis for the next several years, are a number of urgent health problems which demand solution. These include environmental pollution as it affects health, the care of the aged, the treatment of individuals with mental health disorders, the problems of population density, or the terrifying problems of drug abuse by many of our young people. Obviously, these areas deserve immediate attention and large expenditures of effort and of money. Our exclusion of such programs in no way means that we do not recognize their importance, but is simply a consequence of our conviction that to make progress in the areas we have selected will depend in large measure on our ability to concentrate our resources on them.

Further, while there are serious inequities in available health care, the same is true in other major aspects of our national life, such as housing, nutrition, education, and employment. All of these contribute in important ways to health, or lack of it, and we do not mean to imply that more accessible medical care of itself inevitably assures better health. Many of our most lethal illnesses stem from the ways in which we use automobiles, alcohol, and drugs, or neglect our bodies; these illnesses are not susceptible to medical intervention working in isolation from other sectors of society. But this is not at issue here. Americans have indicated a deep desire to have what medicine and health care has to offer them, and they want it more readily available than is currently the case. This, in our judgment, is a worthy and appropriate social goal for The Robert Wood Johnson Foundation.

The goal of change

Obviously, our efforts will give rise to questions which time and experience can help to answer: "Can a private philanthropic organization help our country move toward equity in obtaining frontline health services? Can purposeful change in our delivery of health and medical services be accomplished in our complex and pluralistic society in a period when so many other societal services are found wanting?" We believe that the answer to these questions is "yes."

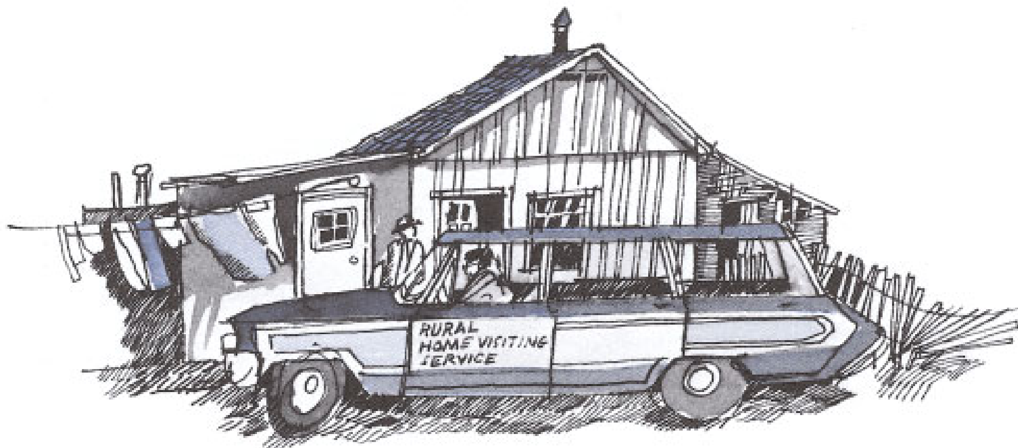
First, health care is not static like agricultural practices in a tribal society. It is changing all the time, and many modifications have occurred during the last 50 years. In part, this is because the system contains such a large technologic component, and our society adapts to new uses of technology with relative ease. Also, changes in our way of life cause significant changes in the health system, for health care practices more closely mirror the way of life of a people than is

commonly emphasized. Thus, changes have been, for better or worse, occurring quite rapidly. But most of the changes to date have been unplanned and have resembled evolution in nature. Some innovations or "mutations," once in place, have been recognized as both meeting a need and fitting a particular situation and consequently have persisted. However, most innovations, even those potentially good, have not had the survival value because of limited visibility, too narrow a focus, or too short a time frame to keep up with the needs and expectations of society.

We hope that purposeful change can operate in a more rapidly beneficial way. The potential advantages of a program of purposeful change is simply that it may considerably multiply the number of individual innovations and, hence, may speed things up. Obviously, the efficiency of the process will depend on the predictive abilities of those who would aid it, and generally speaking, this predictive ability is poor. However, the ability to project appropriate directions for improvement of our world is by no means non-existent, and we will seek to help those who would refine it. Basically, the question really is: "How can we diagnose or identify an idea 'whose time has come'—or more accurately, 'can come'?" This is, of course, a mark of great statesmen, educators, or industrialists. It is also a mark of great foundations.

That there are no solidly established techniques by which broad social change can be produced on purpose is perhaps just as well, for if our social structure were easily manipulated, our free society would be at hazard. But to avoid examining our system of delivering health care would be to deny the mounting evidence that the greatest unmet need is for thoughtful and sensible adjustments in the system itself. Consequently, despite its complexities, it is to this issue that we will direct our attention during our initial years.

We believe that multiple approaches directed at bettering the delivery of health services should be encouraged. One way—that of superimposing a master plan for health from above—seems to promise little for American society. Recent decades have seen quite general disillusionment with the idea that centrally planned and centrally directed social innovation will be accepted. Neither the intrinsic merit of an idea nor the prestige of its advocates offers assurances that it will get picked up and widely applied. Thus, quite fortunately, The Robert Wood Johnson Foundation could not, even if it would, decide on its own what changes would be beneficial for our health care system and set forth to carry them out. In this country, induced change is not a process that can be "directed" from some remote headquarters. It is one that requires the collaboration of many forces. Consequently, in seeking to accelerate beneficial change, we plan to support a variety of approaches toward the same end—and at times, approaches based on concepts that are contradictory to one



another. Expressed differently, we have chosen a fairly definitive outcome goal—that of achieving equitable entry into health services of respectable quality. It seems proper to state our goal unequivocally. It may even be reasonable to set some time frames. However, it does not appear realistic to attempt to define in advance how to get there. In the final analysis, it will be the success or the quality of the end results which will make a difference. There are many roads to Rome, and we will encourage institutions and individuals trying different routes. We believe this will also prevent us from indulging in omnipotent kinds of thinking. We have selected as an objective a goal shared by most Americans. We and society will be enriched and educated by encouraging and evaluating pluralistic approaches to its attainment.

To effect worthwhile social change, we believe The Robert Wood Johnson Foundation's grant program must also be realistically timed to coincide with the readiness of society to take action—or, more accurately, so that the results of the studies we support are available immediately preceding this period of readiness. Clearly, the time frame will vary with the problem at hand. Some programs will hopefully yield useful results in periods counted in months. Others—thorny, contentious, and complex—will require longer periods of nurturing before they can move into the mainstream of public attention. However, we will be attempting to support activities that look like fundamental approaches to the problems outlined and that offer promise of continuing life on their own. We will also provide an opportunity for helpful new approaches to get their run through the gauntlet of public

examination and evaluation. Here timing will often be as critical to the success of our efforts as the careful selection of programs.

We are limiting our work at the outset rather sharply to a few selected areas because history also suggests that meaningful change is brought about only when there is a critical mass of people or institutions working on the solution of a particular problem. Further, though we will encourage exploration of the now unknown and hopefully expand the body of information that can aid society with its problems, we wish to be both reasonably practical and pragmatic. We want to create more equity in the availability of quality care and we will continually evaluate our performance against how well we move toward that goal.

Lastly, we hope to remain highly humanistic, curious, and helpful to those who consult us. Many precious ideas and hopes cross our desks, and individuals who have generated them come often to our offices. Although we cannot possibly support them all, there are many refreshing, new, and exciting human hopes which are presented to us, and we have the rare opportunity of helping some to achieve their aspirations. As a colleague put it: "We are privileged to have the equivalent of senior fellowships to examine virtually any problem in health which confronts this nation, and we have the opportunity to aid some who seek to improve it."

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

Description of selected grants

Description of selected grants

The 226 grants awarded by the Foundation in 1972 are best understood against the background of the issues discussed in the preceding presidential statement. This was a formative year devoted to recruiting a professional staff and defining program objectives. Thus, most of the projects funded were well-developed and were considered capable, with Foundation support, of significantly improving the obvious problems at which they were directed. They are not necessarily representative of programs which the Foundation will fund beyond 1972.

Grant commitments approved by the trustees during 1972 exceeded $44 million. Of this total, efforts to improve access to primary care received $34 million. Projects to improve the quality of American health care received more than $7 million. Programs in public policy research and analysis were awarded $1.4 million. Other projects in health and medical care, and selected organizations and institutions in New Brunswick, New Jersey, where the Foundation was established, received $1 million.

A complete listing of grants appears on page 52.

Access to primary care

Increasing educational opportunities

To help medical and dental schools attract more students who might elect to practice in underserved urban and rural areas, and to increase the number of students coming from minority backgrounds, the Foundation awarded $14 million to be expended during the next four years. These funds provide the nation's schools of medicine, osteopathy, and dentistry with scholarship and loan support for women, students from rural backgrounds, and students from the country's black, Indian, Mexican-American, and U.S. mainland Puerto Rican populations. The Association of American Medical Colleges in Washington, D.C., and the American Fund for Dental Education in Chicago are assisting the Foundation in the administration of these programs.

Two compatible studies should aid in identifying how students make choices about different kinds of medical careers and how they function in them, and should help medical schools to select students who will elect primary care careers or practice in areas now sparsely served by health professionals.

Over the past 15 years, Dr. Daniel H. Funkenstein of the Harvard Medical School has collected data which is now yielding valuable information on what kinds of students select certain kinds of medical careers. His preliminary studies indicate a high correlation between certain kinds of background characteristics and aptitudes, and the types of careers subsequently selected.

Complementing this study of career preference is a study in career choice being directed by Dr. Harrison G. Gough and Dr. Wallace B. Hall of the Institute of Personality Assessment and Research at the University of California at Berkeley. These two collaborators over the past 15 years have compiled comprehensive information on more than 900 medical students from their premedical studies through their M.D. and post-graduate training. Analysis of the data collected to date indicates that the characteristics and traits of students with skills and aptitudes for clinical medicine and community practice can be identified.

An extension of this study through these students' practice choice should yield valuable information on the factors affecting practice location and the stresses and rewards of different kinds of medical careers. Both of these studies received support to permit their completion and publication.

Broadening educational programs

Medical education's emphasis on inpatient hospital care and basic biomedical research, has meant that students have little opportunity to gain experience in community-based ambulatory care. Understandably, the focus on hospital care was chosen because it provides a concentrated and necessary exposure of students to life-threatening problems and can be carefully monitored and supervised. However, only a small segment of a practicing physician's daily experience involves hospital patient care, and this recognition has led a number of medical centers to develop community-based ambulatory care teaching units comparable in quality to the best educational experiences offered within their teaching hospitals. Several have received support.

Meharry Medical College in Nashville, Tennessee, has moved swiftly over the last three years to develop an educational program firmly rooted in community ambulatory care. From the beginning of professional education Meharry stresses a team approach to primary care through community-related ambulatory care centers closely affiliated with the college, which give comprehensive care to over 120,000 people. Thus, Meharry students have ample opportunity to observe and apply the principles of good ambulatory care in an urban area. They also have additional opportunity to see

the problems of rural people needing care because of Meharry's close links with a rural health clinic in the Mississippi Delta and family practitioners throughout the South.

Because of this emphasis, the Foundation provided Meharry Medical College with a grant of $5 million to enable the college to enlarge its clinical faculty and its educational program for teaching medical and dental students and other health professionals preparing for careers in primary care.

The fact that Meharry has supplied one-half the nation's practicing black physicians and 80 per cent of those practicing in the 13 southern states, adds significance to this institution as a national and regional resource.

A new medical school being developed by the University of Nevada at Reno sees educational advantage and efficiency in its integration of pre-professional undergraduate education with professional training. The Nevada program should also demonstrate how universities in sparsely settled states can make the most effective use of their resources in preparing more health professionals for their regions.

The health sciences program being developed by the University of Nevada has the faculty of its new School of Medical Sciences intimately involved in the planning and teaching of pre-professional courses for undergraduates, thus avoiding duplication of faculty and facilities, while at the same time shortening the period required for a professional degree. Students interested in careers in medicine, nursing, and the allied health professions share a common curricula at Nevada for the first two years of college on the premise that those expected to work together upon graduation should have a common educational experience, no matter what their ultimate career will be. The final two undergraduate years are devoted to the students' professional majors, and include substantial instruction by a faculty team delivering health care at a clinic near Reno. Thus, students choosing medicine may enter the third year of medical school, completing their medical education six years after high school instead of the traditional eight.

Prior to the development of the Nevada health sciences program, there was no opportunity in the state for medical care training and no more than 11 Nevada residents a year were enrolled in a medical education program elsewhere. Now, less than three years after Nevada started its own medical school, more than 70 students are pursuing medical careers. It is hoped that many of them will return to practice in western rural areas, helping to alleviate the critical health manpower shortages in these areas.

In a different setting, the University of Illinois' Abraham Lincoln School of Medicine in Chicago encourages medical students to serve in underserved urban poverty areas through an experimental program of urban medical preceptorships. In its initial three years, medical and other health professional students from the Abraham Lincoln School and eight other medical schools, have spent 12 weeks with a professional acutely sensitive to the health problems of the inner city examining the range of health problems found in an urban poverty community.

The program has demonstrated that intense exposure to the problems of delivering health care to the urban poor, and a close working relationship with a preceptor who has made a commitment to service among this population, encourages students to seek careers in underserved urban areas. Most of the medical students who have been in the urban preceptorship program to date, plan to take residency training in community medicine, internal medicine, or pediatrics in preparation for a career within an inner city poverty area. The Foundation is funding an extension of this experiment to test the thesis that the career choice of newly-trained physicians can be stimulated in the direction of primary care to inner city poverty areas by such an educational experience.

The Foundation is also contributing to the costs of a program developed by the Duke University School of Medicine's Department of Community Health Sciences, in which primary care is offered in two different clinical settings staffed by health professionals willing to engage in a systematic evaluation of their work. One is the campus health services clinic which features a busy generalist group practice dealing with the kinds of problems handled by most physicians daily. The other is a network of community health clinics serving a predominantly black urban area and two contiguous rural areas, designed to help local residents understand their health problems and the educational and preventive measures they can take to deal with them. Through direct involvement in this program, Duke faculty and medical students should gain valuable insights into the health status, living conditions, and the prevailing economic, social, and attitudinal barriers which often interfere with the attainment of good medical care.

Utilizing non-physician professionals

A significant improvement in access to primary care could be realized by the careful use of health workers who can free physicians to devote themselves to the diagnosis and treatment processes requiring special physician skills. These new mid-level health professionals include physicians assistants, child health practitioners, nurse practitioners, and family care assistants. The Foundation has provided funds for a few programs training these new kinds of non-physician professionals, particularly in settings where the education is conducted jointly with medical students, so that the team approach to medical care can be more adequately tested in this country. Previously described programs at Meharry Medical College, the University of Nevada, and Duke University include this particular feature. Three additional programs receiving funds stress the team relationship.

The Health Services Corporation of the Church of Jesus Christ of Latter-day Saints, through its Utah Valley Hospital in Provo, is establishing four rural health clinics to be staffed by nurse practitioners living in the southern part of Utah, a region where mountainous terrain and travel distances effectively isolate many communities from medical assistance. There are few doctors and nurses, and the nearest hospitals are small institutions of a few dozen beds and often more than 100 miles away. As a consequence, the death rate from accidents in such areas is three and one-half times that of the state's more populated metropolitan areas and the infant mortality rate is more than twice the rate of the entire state.

Nurses living in this rural area will receive additional training in the Utah Valley Hospital emergency center to qualify as nurse practitioners, and following their return to their home area, their clinic work will be supported by weekly visits by the physicians who trained them, and by a 24-hour telephone service backup from the hospital emergency center. This rural health network will be evaluated during a three-year developmental period with the hope that this kind of program can be extended throughout Utah, Idaho, and Wyoming. Rural clinics linked to a regional hospital promise an effective way to build a health services network for isolated communities with difficulties in obtaining adequate care.

A similar program at the University of California at Davis is providing registered nurses who live in rural areas in northern California additional training as family practice assistants. Practicing physicians serve as preceptors and subsequently employ the nurses in this expanded role to increase health services lacking in their home communities.

The nurses are flown weekly to Davis for one year to attend classes, while simultaneously receiving clinical training from the physician in their home communities. This is followed by a subsequent six-month "internship" under the supervision of the physician preceptor.

To advance the skills needed by a group responsible for formulating an organized plan to meet a patient's need, the Foundation is supporting a two-year study of the team practice concept by the Alfred P. Sloan School of Management at the Massachusetts Institute of Technology. The Sloan School expertise in corporate management and industrial relations will be applied to developing staff capabilities to function as organized teams, improving health professional-patient relationships, and strengthening the leadership skills necessary to implement organizational change. From this study, the project directors hope to produce course materials for in-service education of staffs of health institutions, and students in medicine, nursing, and other health professions.

Building new health service systems

Except for receiving routine immunizations in childhood, and prenatal care as expectant mothers, most Americans seek medical assistance only after illness strikes. Recently prepaid group practice plans have emerged as alternative ways of delivering comprehensive medical care, offering preventive as well as illness-oriented care for a fixed prepaid premium. Studies of a number of the larger prepaid group practice plans suggest that they can yield lower hospitalization rates and lower annual health costs for a family, without erosion of the quality of care. In the last several years hospitals, community groups, labor unions, insurance companies, and some medical schools have had increasing interest in developing prepaid group plans, but the start-up costs during the initial enrollment period have been deterrents for many.

Because prepaid group plans may provide new kinds of opportunities to train physicians in both ambulatory and in-hospital care competence, the Foundation has assisted in the planning and development of several programs which stress comprehensive, continuous coverage and are explicitly intended to advance teaching and research in community-oriented health and medical care. These include a community-sponsored effort in rural California, and three university-affiliated group practice plans.

The 50,000 people living in the City of Martinez and its surrounding rural Contra Costa County of California have been medically underserved, requiring the majority of patients to travel great distances out of the area to get medical care. The situation is not unlike that facing many other rural and semi-rural counties in the nation. The below-average incomes, scarce health facilities, and physician isolation from colleagues and modern facilities and equipment have made health care a major problem.

The rising costs of health insurance programs in the area, and the aging community hospital in Martinez which faced condemnation, generated new plans for improving the health care system of this area. In 1969, the Contra Costa Labor Health and Welfare Council, a non-profit association of 56 affiliated unions, enlisted the support of multiple groups in Martinez and Contra Costa County and formed the Martinez Health Center, Inc. The Labor Council donated land, free labor, and guaranteed payment of bonds to support the construction of the new hospital and ambulatory center, financed from local sources.

A liaison was also developed with the University of California at Davis which will rotate graduates of residency programs in family practice, medical school residents, medical students, and graduate nurses through the Martinez Health Center so they become familiar with the problems and challenges of providing community care in a rural setting.

In addition to this program, three university-affiliated prepaid group plans received assistance from the Foundation.

The Harvard Community Health Plan was started in 1969 under the sponsorship of the Harvard Medical School in cooperation with four of the Harvard teaching hospitals. The

first of several proposed centers opened in downtown Boston and has grown to 28,000 enrolled members. A similar center, planned for Cambridge in cooperation with the Cambridge City Hospital, would serve as a teaching unit for the medical school, and demonstrate how universities can collaborate with a nearby community hospital, physicians, and citizens to improve access to quality care.

The Community Health Care Center Plan in New Haven, Connecticut, which is affiliated with the Yale-New Haven Medical Center, provides 24-hour ambulatory, hospital, and home care as well as a teaching and research site for Yale medical students. Foundation funds helped ensure that the New Haven plan can expand its operation to include a diverse population.

Georgetown University in Washington, D.C., is establishing three group practice centers to serve low- and middle-income inner city Washington residents, the campus community of the university, and the "new town" of Reston, Virginia. The Georgetown medical faculty, the University Hospital and its affiliated institutions, are deeply involved in creating these comprehensive medical coverage plans.

To further assess the long-range importance and implications of prepaid group plans, the Foundation provided support to the Center for Information on America to work with experts in the field to prepare, publish, and distribute a booklet describing existing prepaid group practice systems so that the public can become better acquainted with the advantages and problems faced by this approach to health care in the United States.

The first years of life

Increasing evidence suggests that early childhood environment, nutrition, and family relationships determine to an important degree the subsequent abilities of an individual to learn, to grow, and to become a responsible member of society. The first years of a child's life are marked not only by rapid physical growth, but also by the development of basic personality characteristics and skills in learning and the ability to relate to others. For a number of children, physical, mental, neurological, or social deficits retard growth. Thus, by the sixth grade one of four boys and one of five girls fail to perform at grade level. Recognition of these problems, or intervention, or treatment only when a child reaches school age is sometimes too late.

One step toward giving better help to children and their families during infancy and early childhood has been organized by the Brookline, Massachusetts, public school system. This group envisions a new role for public education by looking at the health of a child and his family on a systematic preschool basis, beginning at birth.

Brookline resembles many American towns with a population of about 54,000, one-half of its families earning less than $10,000 a year, and a great majority of its children enrolled in public schools. Families with a newborn infant or who are expecting a child will be identified with the assistance of local physicians, hospitals, and community groups, and be invited to enroll in the Brookline program. Information on the status, growth, and development of the infants, and the relevant family history of those enrolling will be recorded to identify "high risk" factors in the infant's growth and development, and to guide parents on ways to help the child reach his potential. Parents will be given medical guidance from the start of the mother's pregnancy through the early years of their child, and should realize an early and sustained relationship with the child's school system. The faculty of the Harvard Graduate School of Education and Children's Hospital in Boston will participate in the project. The Foundation has joined the Carnegie Corporation in supporting implementation of this interesting and potentially important program.

It is estimated that 60,000 children annually

suffer serious inflicted injuries or severe physical and emotional deprivations at the hands of their parents, and such maltreatment occurring in early infancy almost invariably leads to major psychological or physical impairment and frequently to mental retardation. The University of Colorado Medical Center has pioneered in identifying parental abuse and neglect of children as a health problem in the United States. The damage to the child's health and abilities to subsequently function normally has been clearly established in these early efforts, supported by the Commonwealth Fund.

Dr. Henry C. Kempe, the program director, and his staff are now planning to extend the Colorado program by establishing a national center on child abuse and neglect for training health professionals in the diagnosis and treatment of child abuse; maintaining a 24-hour telephone referral service; and consulting with hospitals, courts, community agencies, and state legislatures wishing to adopt preventive procedures in their communities.

The Colorado staff has determined that the causes of parental abuse and neglect appear to lie in the childhood of the parents. Typically, the parents were subject to excessive demands and rigid discipline from their own parents and in turn place on their children the same burden of unrealized expectations. When children fail to respond as desired, the parents either attack their children or punish them through neglect. The Colorado group has demonstrated that this is a potentially preventable or reversible disease, and that intervention in child abuse cases can dramatically reduce the physical and psychological damage in children, enabling over 80 per cent to be safely returned to their parents with no recurrence of abuse. Treatment leading to a reunion with the parents is important, for the child is not deprived of a home and society is spared the cost of his long-term foster care.

The Foundation is supporting formation of the national center because it considers the Colorado program a resource capable of providing critically-needed information on the physical and emotional health care of infants and children, and because the program signifies that there is an expanded role for the university medical center in community health issues.

The quality of health care

Increasing physician management skills

Classically, medical education has concerned itself almost exclusively with training physicians to deal with individual instances of illness. As the complexity of our needs in health care increases, more physicians who combine superior clinical skills with behavioral and social science knowledge and the analytic capability of examining broad health care problems are needed.

One promising approach to broadening the training of young clinicians was initiated three years ago by five medical schools—Case Western Reserve, Duke, Stanford, Johns Hopkins, and McGill University in Montreal. With support from the Commonwealth Fund and the Carnegie Corporation, a group of young physicians who had received clinical residency training and wished to develop additional skills for evaluating and managing health care systems were awarded training grants to prepare for careers in these areas.

While limited in extent, the program received considerable attention and has begun to provide physicians who are competent in their clinical fields and specifically qualified to provide leadership in the solution of certain problems of health care services and systems. In addition to their medical studies, these "clinical scholars" undertake graduate level study on such topics as the economics of hospitals, municipal health systems, and national health insurance programs; the

education of non-physician professionals; the factors which govern community acceptance of health programs; the quality of the doctor-patient relationship; outcome measurements of illness; the organization of neighborhood clinics; or the integrated organization of many types of health care institutions within a large geographic region. The majority of these clinical scholars are already medical school faculty members with key assignments to strengthen the schools' capacity to deal with the problems of health care delivery, or play equally important new roles in health.

During the next several years the Foundation will expand this experiment to a major national program. Dr. John C. Beck, a distinguished medical educator, scientist, and clinician who is currently chairman of medicine of the Faculty of Medical Sciences at McGill, will become full-time executive director of the new Robert Wood Johnson Clinical Scholars Program. A national board of directors representing a broad spectrum of national and medical interests will work closely with Dr. Beck to develop and evaluate this program, with the goal of enlisting some of the nation's best young medical talent in these new types of health service careers.

Improving performance standards

Health professionals agree that the way in which health and medical information on individuals is gathered, recorded, and stored is in need of overhaul. In general, medical transactions are recorded as a series of unrelated episodes, and the information is stored in different hospitals, different clinics, and different doctors' offices, so that an orderly integration of the information about a patient is often difficult, if not impossible. No easily understood record accompanies the patient, and thus, those who give him care lack a clear accounting of the patient's problems or what measures have been taken to manage them. As a result, patients often must verbally repeat half-understood fragments of medical knowledge when seeing different physicians, and diagnostic tests must be repeated with considerable cost and delay.

At the University of Vermont, Dr. Lawrence L. Weed and his colleagues pioneered a patient record system which promises to permit physicians or other health professionals to act with greater understanding of previous care. In the new record, a patient's problems are fully defined and listed, and then are systematically pursued in order of importance. It seems probable that Dr. Weed's problem-oriented patient record system can serve as the prototype of a record readily adaptable for broader use in medical practice and better evaluation of reasoning skills in diagnosis and treatment. It already has been adopted in many institutions to teach basic skills of clinical methodology and judgment, and in many practice settings.

The Foundation is supporting the first steps toward the extension and testing of this single record throughout the University of Vermont hospital and ambulatory patient care system, and the development of information texts for other applications. This record would be stored on a central computer and be available via television screen terminals to doctors' offices, emergency clinics, hospital laboratories, and the pharmacy, so that all involved can instantly check a patient's status.

Assuring quality of care also involves appropriately educated manpower whose role and functions are defined to permit accurate assessments of their effectiveness on the job. Although the concept of physicians assistants trained to assume many of the functions normally performed by the physician is increasing, job functions and performance standards are not well defined. From a few pilot projects begun a few years ago, the number of practicing physicians assistants has grown to 300 and another 1,400 are in training. Initial programs have demonstrated that these new health professionals can assume

responsibility for a sizable portion of first contact medical care, but the absence of a set of agreed criteria for qualifying graduates for service has resulted in greatly varied levels of training and uncertainties about the competence of all being trained.

The National Board of Medical Examiners, in response to numerous state requests, is developing a national examination system for certifying physicians assistants on the basis of experience as well as classroom credentials—an approach of particular importance in teaching programs which are including people with varying levels of prior experience, including medical corpsmen, nurses, and social workers.

Educating the users of health services

Whether health care information made available to a mass audience on a continuing basis can lead to improvement of individual health maintenance remains undetermined, but some uses of television as an educational medium for a mass audience have shown promise. Two efforts by the Children's Television Workshop (CTW) in New York, "Sesame Street" and "The Electric Company," have shown that, at least for children, the collaboration of subject matter experts with talented producers, writers, directors, and performing artists can produce entertaining broadcast materials with specific educational objectives which can result in significant learning. With the support of various foundations, CTW is using this experience to plan a series of hour-long programs on health care to be carried by the Public Broadcast Service. These programs are to be targeted for young adult viewers, particularly young married couples.

Public policy issues in health

Formulating alternative health policies

Funds were awarded to the University of California at San Francisco to develop a health policy center which promises to play an important role in teaching scholars and career public servants the economic, statistical, and political implications of health programs. Plans for the center were developed by Dr. Philip R. Lee, the former chancellor of the university, who previously served as assistant secretary of health and scientific affairs in the Department of Health, Education and Welfare (HEW), and Lewis Butler, former HEW assistant secretary for planning, programming and budgeting, and now professor of law at the University. This center should be an important regional and national resource meeting two specific needs: research on specific policy problems to point to available options for action, and detailing the policy implications and probable outcomes of proposed legislation in health.

For many years, the National Academy of Sciences has been the country's most important organization concerned with the role of science and its institutions in the improvement of human welfare. Recently the Institute of Medicine was organized by members of the Academy to serve as an independent, objective resource for identifying and analyzing fundamental problems and issues specifically affecting the advance of health and biomedical research in the United States. This impressive new American institution received support from the Foundation with the hope that its studies and its programs for disseminating results to decision makers in the health field as well as to the general public will contribute to a greater understanding of health policy questions.

The lack of economic measurements and tools and a shortage of economic analysts in

the health field provides serious impediments to effective planning, organization, and policy formulation in health care. The National Bureau of Economic Research plans to expand its work in health economics through its Center for Economic Analysis of Human Behavior and Social Institutions. With Foundation support the center's health unit will develop research programs in health policy; predoctoral and postdoctoral programs for young economists and health professionals who wish to specialize in the health research field; and make the results of the center's programs available to scholars, government officials, business leaders, and others interested in the field.

Evaluating existing health policies

In the years ahead, budgetary pressures will force hard decisions about the allocation of limited national funds for health care. While huge sums are now being spent on health, to date the effect of the dollars being paid out to provide medical assistance to various groups has not received careful, objective evaluation. Thus, much is unknown about how the monies expended have affected the actual distribution of benefits, improved existing medical services, or their impact on the costs of health care.

With Foundation support, the Brookings Institution in Washington, D.C., is sponsoring a two-year study by Karen Davis on the effect of government health programs aimed at improving access to medical care for the poor. This will be a comprehensive study of the national investment in Medicare, Medicaid, and the health programs of the Office of Economic Opportunity, and should yield data on the impact of present federal programs on health status, the utilization and distribution of resources, and the costs and structure of care.

The Committee for Economic Development (CED) is an independent organization of some 200 senior executives from business, finance, and university education who are committed to strengthening the private sector role in the solution of current public problems. CED carries out this objective by study of critical policy questions, making its findings and recommendations known through an active information program. CED recently completed a study of the national system of health care, titled "Building a National Health-Care System," which focuses on the problems of organization, management, and finance which have become particularly compelling with the likely advent of a national health insurance program. The Foundation has helped to support the development of this policy statement in the interest of contributing substantive documents affecting timely and significant policy decisions for the nation.

Foundation operations

During the year, the trustees and officers gave major attention to developing the Foundation's staff. In November, 1971, that staff consisted of the chairman and the board secretary. By January, 1973, the staff had grown to 38 people, including 20 professional and administrative personnel.

Terrance Keenan, who joined the Foundation in March, 1972, as senior executive associate, was named vice president for grants management in November. With his extensive background in foundation operations at an executive level, he has helped us move rapidly to establish procedures and standards for professional excellence in philanthropy.

Dr. Walsh McDermott, a distinguished medical educator and public health authority, joined the Foundation staff on a part-time basis as special advisor to the president in July, 1972. For the past 17 years, Dr. McDermott had been the Livingston Farrand Professor of Public Health and chairman of the department of public health at New York Hospital—Cornell Medical Center. He continues an affiliation with the Cornell Medical Center as professor of public affairs in medicine. Dr. McDermott has had long experience as a clinical investigator, teacher, and as major contributor to the nation's health and scientific institutions. For his work in the drug therapy of tuberculosis, he shared an Albert Lasker Award in 1955. Dr. McDermott is co-editor of the Cecil-Loeb Textbook of Medicine, served as chairman of President Johnson's White House Task Force on American Indians, and was chairman of the National Academy of Sciences' Board on Medicine which led to the formation of the new Institute of Medicine.

William R. Walsh, Jr. joined the Foundation as treasurer in January, 1973. He had previously served as vice president for administration and finance of Middlesex County College in Edison, New Jersey, and brings experience in institutional finance and administration to the Foundation. He continues to serve Middlesex County College as a trustee.

Two assistant vice presidents also were named to the staff in early 1973. Dr. Alfred M. Sadler, Jr. and Blair L. Sadler are brothers and professional colleagues. Alfred Sadler is a physician, and Blair Sadler is a lawyer. They are joining the Foundation from the faculty of the Yale University School of Medicine, where they have developed the university's Trauma Program which has become a model for the

design of coordinated regional systems to deal with accidental trauma and emergency care. They are also co-authors, with Ann A. Bliss, of "The Physician's Assistant—Today and Tomorrow," the most comprehensive book to date on the role of this new non-physician professional.

Four executive assistants joined the professional staff during 1972. Carol Richards had worked in the health program of the Carnegie Corporation as a staff assistant before coming to the Foundation. Annie Lea Shuster had been with the Commonwealth Fund, where she had had experience with grants administration and medical center organization. Frank Jones, a Rutgers graduate with a background in newspaper journalism, had most recently been director of community relations at William Paterson College in Wayne, New Jersey. John Murphy, an experienced editor, had been director of publications at Lehigh University in Bethlehem, Pennsylvania.

Rubie Baysinger, a Rutgers graduate with extensive library experience, is responsible for building the Foundation's important and expanding library. Mae Lani Sanjek, a Barnard graduate, joined the Foundation as a research assistant in December. She had previously been a staff assistant at the Carnegie Corporation.

During the year, the board of trustees met eight times at the Foundation offices in Princeton, New Jersey, with the regular annual meeting convened in April.

Stuart Carothers
Secretary

Financial statements

Introduction to statements

Pursuant to the Tax Reform Act of 1969, the Foundation was required to distribute for 1972 its adjusted net income or 4.125 percent of the aggregate fair market value of its assets, whichever is greater.

Under this rule, payout requirements for 1972, net of expenses, Federal excise taxes, and excess payments carried forward from prior years have been calculated to be $44,570,378. During the year, a total of $24,519,841 in grants was paid out, and an additional $19,519,133 was allocated to grantee agencies for payment in 1973 or later. The balance of $531,404 will be allocated and paid in 1973.

At January 1, 1972, the Foundation owned 11,911,767 shares of Johnson & Johnson Common Stock, which represented 21.2 percent of the outstanding shares of the company. At December 31, 1972, it owned 9,949,215 shares, which represented 17.6 percent of the total shares outstanding.

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, 1972, 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.

In our opinion, the aforementioned financial statements present fairly the financial position of The Robert Wood Johnson Foundation at December 31, 1972, and the investment income, expenses, grants, and the changes in foundation principal for the year then ended, in conformity with generally accepted accounting principles which, except for the change (with which we concur) in the recording of unpaid grants as described in Note 1a to the financial statements, have been applied on a basis consistent with that of the preceding year.

Lybrand, Ross Bros. & Montgomery

Newark, New Jersey
February 1, 1973

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

Assets		
Cash		$ 325,628
Securities (at cost, or market value on dates of gifts) (Note 2):		
9,949,215 shares Johnson & Johnson common stock (quoted market value $1,295,885,250)	$282,069,139	
500,000 shares Ford Motor Company common stock (quoted market value $39,781,250)	27,120,300	
Other securities (see page 49 for listing) (quoted market value $174,176,880)	174,355,755	483,545,194
Furniture and equipment, at cost (net of depreciation)		103,469
		$483,974,291

Liabilities and Foundation Principal		
Liabilities:		
Unpaid grants (Note 1a)	$ 19,519,133	
Drafts payable—grants	993,492	
Federal excise tax payable	4,029,817	
Total Liabilities		$ 24,542,442
Foundation Principal:		
Appropriated for 1972 payout requirement (Note 3)	531,404	
Unappropriated balance	458,900,445	
Total Foundation Principal		459,431,849
		$483,974,291

See notes to financial statements, page 48.

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

Investment income:		
Dividends	$ 5,479,432	
Interest (Note 1b)	5,031,541	$ 10,510,973
Less direct investment expenses and Federal excise tax		485,044
		10,025,929
Expenses:		
Salaries, employee benefits and payroll taxes	475,895	
Professional services	120,163	
Rent and leasehold improvements	130,587	
Meeting and travel expenses	43,863	
Other administrative expenses	162,078	932,586
Income available for grants		9,093,343
Grants (Note 1a)		44,038,974
Excess of expenses and grants over investment income		(34,945,631)
Additions to Foundation Principal:		
Net capital gains on sales of securities	190,546,898	
Less related Federal excise tax	3,613,315	
	186,933,583	
Contributions received:		
Trusts	302,713	
Individuals	1,525	187,237,821
Net increase in Foundation Principal		152,292,190
Foundation Principal at beginning of year		307,139,659
Foundation Principal at end of year		$459,431,849

See notes to financial statements, page 48.

Notes to financial statements

1. Summary of significant accounting policies:

   (a) In the year grant requests are approved by the board of trustees, they are recorded in the accounts as unpaid grants. Prior to 1972, grants were recorded in the accounts in the year of payment. If the Foundation had followed the current policy in the preceding year, 1972 grants would have been reduced by $8,325,000 which represents the amount of unpaid grants at December 31, 1971.

   (b) Interest income is recorded on the cash basis. At December 31, 1972 and 1971, the amounts of unrecorded interest income were approximately $2,500,000 and $48,000, respectively.

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

3. Pursuant to the Internal Revenue Code, as amended in 1969, the Foundation must distribute through qualifying grants each year the higher of the minimum investment return or adjusted net income, as those terms are defined in the Code. Refer to the introduction to these statements on page 44 for details.

4. The Foundation has a non-contributory insured pension plan covering all eligible employees. Pension expense approximated $42,000 for the year ended December 31, 1972.

The Robert Wood Johnson Foundation
Other securities
At December 31, 1972

	Face amount	Cost	Quoted market value
U.S. Government obligations:			
Bills due 3-8-73	$ 1,350,000	$ 1,333,236	$ 1,336,851
6% treasury notes due 9-30-74	6,000,000	6,011,094	6,007,500
5⅞% treasury notes due 5-15-75	37,000,000	37,090,313	36,837,940
5¾% treasury notes due 5-15-76	7,000,000	7,028,437	6,912,500
	51,350,000	51,463,080	51,094,791
Bank certificates of deposit:			
Bankers Trust Company			
5¾% due 6-1-73	5,000,000	5,000,000	4,999,000
Chase Manhattan Bank			
5.35% due 1-29-73	2,000,000	2,000,687	1,999,400
Harris Trust & Savings Bank			
5¾% due 5-29-73	5,000,000	5,000,000	4,999,000
Irving Trust Company			
5⅛% due 1-22-73	5,000,000	5,004,031	4,998,500
	17,000,000	17,004,718	16,995,900
Other bonds and notes:			
Bankamerica Corp.			
6⅝% notes due 2-1-80	3,000,000	2,986,800	2,962,500
Beneficial Corp.			
6¾% debentures due 7-15-79	2,000,000	2,000,000	2,005,000
7½% debentures due 7-15-02	3,000,000	2,982,000	3,060,000
Chemical New York Corp.			
6⅝% notes due 4-15-80	3,000,000	2,982,900	2,985,000
Chesapeake & Potomac Telephone Co. of Virginia			
6½% notes due 6-1-78	3,000,000	3,000,000	2,985,000
7¼% debentures due 6-1-12	2,000,000	1,977,500	1,960,000
Commercial Credit Co.			
6⅞% notes due 7-15-79	3,000,000	2,985,000	3,015,000
Consolidated Natural Gas Co.			
7⅝% debentures due 5-1-97	3,000,000	3,036,930	3,067,500
Consumers Power Co.			
7½% first mortgage bonds due 6-1-02	3,000,000	3,018,750	3,045,000

	Face amount	Cost	Quoted market value
Dow Chemical Co.			
7.40% debentures due 7-15-02	$2,000,000	$2,000,000	$2,035,000
Duke Power Co.			
6⅝% promissory notes due 11-1-75	5,000,000	5,000,000	5,000,000
Farmers Home Administration			
6.45% insured notes, series K due 6-30-77	4,995,700	4,978,215	4,958,232
6.55% insured notes, series M due 12-29-77	2,002,756	2,002,756	1,997,750
Federal Home Loan Mortgage Corp.			
7.15% guaranteed mortgage bonds due 5-26-82 to 97	3,000,000	3,013,125	2,962,500
Federal National Mortgage Association			
6.40% debentures, series SM1979B due 9-10-79	6,000,000	5,990,625	5,932,500
6.60% debentures, series SM1980B due 12-10-80	6,000,000	6,003,750	5,962,500
7.05% debentures, series SM1992B due 6-10-92	5,000,000	5,000,094	4,900,000
General Electric Credit Corp.			
6⅝% notes due 8-15-77	5,000,000	5,000,000	5,012,500
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	995,000
Household Finance Corp.			
7½% debentures, series IF due 8-1-95	3,000,000	3,000,000	3,060,000
Leased Tankers Inc.			
6.55% secured notes, series A due 12-1-73	1,400,000	1,400,000	1,400,000
6⅝% secured notes, series A due 12-1-74	1,400,000	1,400,000	1,400,000
Michigan Consolidated Gas Co.			
7⅝% first mortgage bonds due 7-1-97	2,000,000	1,978,125	1,995,000
Northern Illinois Gas Co.			
7⅝% first mortgage bonds due 7-1-97	2,000,000	2,005,540	2,027,500
Northwestern Bell Telephone Co.			
7½% debentures due 4-1-05	3,000,000	3,042,500	3,022,500
Pacific Gas & Electric Co.			
7½% first and refunding mortgage bonds, series YY due 6-1-04	3,000,000	3,000,000	3,026,250
Southern Bell Telephone & Telegraph Co.			
6½% notes due 7-15-79	2,000,000	1,987,500	1,995,000
7⅜% debentures due 7-15-10	3,000,000	2,952,500	3,022,500

	Face amount	Cost	Quoted market value
Southern California Edison Co.			
7⅜% first and refunding mortgage bonds, series BB due 8-15-97	$ 1,000,000	$ 997,170	$ 1,007,500
Southwestern Bell Telephone Co.			
6½% notes due 5-1-79	3,000,000	2,976,250	2,992,500
7⅜% debentures due 5-1-12	3,000,000	2,990,400	3,018,750
Tennessee Valley Authority			
7.35% power bonds, series C due 7-1-97	4,000,000	4,000,000	4,070,000
Textron Inc.			
7½% sinking fund debentures due 7-15-97	2,000,000	2,000,000	2,000,000
Toledo Edison Co.			
7½% first mortgage bonds due 8-1-02	2,000,000	1,995,000	2,027,500
Twelve Federal Land Banks			
6.80% consolidated loan bonds due 10-23-79	4,000,000	4,063,750	4,030,000
	105,798,456	105,737,750	105,935,982
Purchased interest	150,207	150,207	150,207
	$174,298,663	$174,355,755	$174,176,880

The Robert Wood Johnson Foundation
Summary of Grants
For the year ended December 31, 1972

Alabama Health Study Commission
Montgomery, Alabama
Study of health care system

American Fund for Dental Education
Chicago, Illinois
Administration of Foundation's dental student aid program

Association of American Medical Colleges
Washington, D.C.
Administration of Foundation's medical student aid program

Program on management of academic medical centers

The Brookings Institution
Washington, D.C.
Study on impact of government programs on health care for the poor

Town of Brookline, Massachusetts, Public Schools
Brookline, Massachusetts
Detection and prevention of health and learning handicaps in infants and preschool children

University of California, Berkeley
Berkeley, California
Research on selection criteria for training future community doctors

University of California, Davis, School of Medicine
Davis, California
Rural nurse practitioner program

University of California, San Francisco
San Francisco, California
Planning of a health policy center

Center for Information on America
Washington, Connecticut
Information booklet on prepaid group practice

Unpaid grants January 1, 1972	1972 grants authorized	1972 payments	Unpaid grants December 31, 1972
$	$ 61,000	$ 61,000	$
	40,000	10,000	30,000
	40,000	10,000	30,000
	316,440	147,220	169,220
	119,200	59,600	59,600
	400,000	200,000	200,000
	227,000	72,000	155,000
	79,384	79,384	
	164,000	164,000	
	20,000	20,000	

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

Clinical Scholars Program
National program to prepare young physicians for leadership roles in medical care

University of Colorado Medical Center
Denver, Colorado
National Center for the Prevention and Treatment of Child Abuse and Neglect

Committee for Economic Development
New York, New York
Study of U.S. health care organization and financing

Community Health Care Center Plan, Inc.
New Haven, Connecticut
Development of primary care prepaid group practice program

Council on Foundations
New York, New York
Service and educational programs

Dartmouth Medical School
Hanover, New Hampshire
Planning project on rural health care

Dental Student Aid Program
Grants to U.S. dental schools for scholarships and loans (See Schedule A, page 64)

Duke University School of Medicine
Durham, North Carolina
Research and training in primary care community practice

East Kentucky Health Services Center, Inc.
Hindman, Kentucky
Planning of proposed community health center

Easter Seal Society for Crippled Children and Adults
New Brunswick, New Jersey
Expansion of Raritan Valley Workshop

Unpaid grants January 1, 1972	1972 grants authorized	1972 payments	Unpaid grants December 31, 1972
$	$ 37,500	$ 37,500	$
	5,900,000		5,900,000
	588,000	179,412	408,588
	20,000	20,000	
	350,000	200,000	150,000
	60,000	20,000	40,000
	99,540	99,540	
	4,000,000		4,000,000
	1,134,375	365,479	768,896
	20,000	20,000	
	50,000	50,000	

Editorial Projects for Education
Washington, D.C.
Study on public reporting of health developments

The Foundation Center
New York, New York
Statistical research and information on U.S. foundations

Georgetown University School of Medicine
Washington, D.C.
Development of primary care prepaid group practice program

George Washington University School of Medicine
Washington, D.C.
Feasibility study of a health policy center

Harvard Community Health Plan, Inc.
Boston, Massachusetts
Development of primary care prepaid group practice program

Harvard Medical School
Boston, Massachusetts
Research in selection criteria for training future primary care doctors

Harvard School of Public Health
Boston, Massachusetts
Planning program

Hospital Research and Educational Trust of New Jersey
Princeton, New Jersey
Feasibility study of computer-based hospital cost analysis and control system

University of Illinois, Abraham Lincoln School of Medicine
Chicago, Illinois
Expansion of Urban Preceptorship Program

Institute of Public Administration
New York, New York
Health services education program of the Community Health Institute

John F. Kennedy Community Hospital
Edison, New Jersey
Expansion program

Unpaid grants January 1, 1972	1972 grants authorized	1972 payments	Unpaid grants December 31, 1972
$	$ 13,000	$ 13,000	$
	150,000	150,000	
	196,000	140,000	56,000
	25,000	25,000	
	446,106		446,106
	167,250	55,750	111,500
	200,000	200,000	
	60,000	30,000	30,000
	576,390	136,390	440,000
	192,000	192,000	
500,000		500,000	

The Martinez Health Center, Inc.
Martinez, California
Development of primary care prepaid group practice program

Massachusetts Institute of Technology
Alfred P. Sloan School of Management
Cambridge, Massachusetts
Staff training systems for health care institutions

The Matheny School
Peapack, New Jersey
Equipment support

Medical Student Aid Program
Grants to U.S. medical schools for scholarships and loans (See Schedule B, page 66)

Meharry Medical College
Nashville, Tennessee
Improvement of teaching and service programs in primary care

University of Michigan Medical School
Ann Arbor, Michigan
Planning project by School of Public Health on health manpower policy

Middlesex County College
Edison, New Jersey
Nursing and allied health sciences programs

Middlesex General Hospital
New Brunswick, New Jersey
Equipment and expansion program

Middlesex Rehabilitation Hospital
North Brunswick, New Jersey
Equipment support

National Academy of Sciences
Washington, D.C.
Basic program of the Institute of Medicine

National Board of Medical Examiners
Philadelphia, Pennsylvania
National examination system for qualifying physicians assistants

Unpaid grants January 1, 1972	1972 grants authorized	1972 payments	Unpaid grants December 31, 1972
$	$ 350,000	$ 250,000	$ 100,000
	257,929	129,000	128,929
	5,000	5,000	
	10,000,002	9,507,290	492,712
	5,000,000	950,000	4,050,000
	25,000	25,000	
	51,943	21,993	29,950
2,800,000	282,000	3,082,000	
	50,000	50,000	
	750,000	750,000	
	139,950	56,650	83,300

National Bureau of Economic Research
New York, New York
Research and training program in health economics

National Health Council
New York, New York
Self-study of the Council's future structure and role

National Planning Association
Washington, D.C.
Analysis of federal expenditures in health

University of Nevada
Reno, Nevada
Joint training of health professions students in primary care

College of Medicine and Dentistry of New Jersey
Newark, New Jersey
Preprofessional summer study for minority-group students

New Jersey Health Careers Service, Inc.
Trenton, New Jersey
High school student health-career guidance

Proprietary House Association
Perth Amboy, New Jersey
Restoration program

The Richard B. Russell Foundation, Inc.
Atlanta, Georgia
Chair of history, University of Georgia

St. Peter's General Hospital
New Brunswick, New Jersey
Equipment and expansion program

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

St. Vincent de Paul Society
Highland Park, New Jersey
Support for the needy

Unpaid grants January 1, 1972	1972 grants authorized	1972 payments	Unpaid grants December 31, 1972
$	$ 210,000	$ 60,000	$ 150,000
	10,000	10,000	
	19,151	19,151	
	1,051,000	384,418	666,582
	55,000	55,000	
	37,500	37,500	
25,000		25,000	
	250,000	250,000	
5,000,000	250,000	5,250,000	
	24,000	24,000	
	8,000	8,000	

The Salvation Army
New Brunswick, New Jersey
Support for the needy

United Community Services of Central Jersey, Inc.
New Brunswick, New Jersey
Building and general support

University of Vermont College of Medicine
Burlington, Vermont
Development of an electronic system for a unitary patient record

Utah Valley Hospital
Provo, Utah
Network of rural health clinics

Scholarships for medical students*

TOTAL

*This program has been replaced by the medical student aid program.

Unpaid grants January 1, 1972	1972 grants authorized	1972 payments	Unpaid grants December 31, 1972
$	$ 8,000	$ 8,000	$
	156,042	156,042	
	600,000	122,090	477,910
	344,840		344,840
	26,432	26,432	
$ 8,325,000	$35,713,974	$24,519,841	$19,519,133

The Robert Wood Johnson Foundation
Summary of Grants
For the Year Ended December 31, 1972
Schedule A—Dental Student Aid Program

University of Alabama, Birmingham, School of Dentistry	$ 75,830
Baylor College of Dentistry	101,641
Boston University School of Graduate Dentistry	21,410
Case Western Reserve University School of Dentistry	58,423
Columbia University School of Dental and Oral Surgery	54,822
University of Connecticut School of Dental Medicine	45,820
Creighton University School of Dentistry	75,230
University of Detroit School of Dentistry	60,224
Emory University School of Dentistry	78,231
Fairleigh Dickinson University School of Dentistry	48,819
University of Florida College of Dentistry	21,410
Georgetown University School of Dentistry	51,821
Medical College of Georgia	70,027
Harvard School of Dental Medicine	54,222
Howard University College of Dentistry	156,863
University of Illinois College of Dentistry	84,234
Indiana University School of Dentistry	96,238
University of Iowa College of Dentistry	110,044
University of Kentucky College of Dentistry	92,637
Loma Linda University School of Dentistry	72,229
Louisiana State University School of Dentistry	72,829
University of Louisville School of Dentistry	82,433
Loyola University School of Dentistry, Chicago	89,036
Marquette University School of Dentistry	77,631
University of Maryland School of Dentistry	69,828
Meharry Medical College School of Dentistry	116,647
University of Michigan School of Dentistry	96,839
University of Minnesota School of Dentistry	116,046
University of Missouri, Kansas City, School of Dentistry	141,857
University of Nebraska College of Dentistry	120,248
College of Medicine and Dentistry of New Jersey, Newark	50,620
New York University College of Dentistry	60,224
State University of New York at Buffalo	57,223
University of North Carolina School of Dentistry	75,830
Northwestern University Dental School	72,829
Ohio State University College of Dentistry	71,028
University of Oklahoma College of Dentistry	26,809
University of Oregon Dental School	75,830

University of the Pacific School of Dentistry	$ 63,825
University of Pennsylvania School of Dental Medicine	60,824
University of Pittsburgh School of Dental Medicine	66,827
University of Puerto Rico School of Dentistry	85,434
Medical University of South Carolina College of Dental Medicine	62,625
University of Southern California School of Dentistry	65,026
Southern Illinois University, Edwardsville, School of Dentistry	21,410
Temple University School of Dentistry	48,821
University of Tennessee College of Dentistry	136,454
University of Texas Dental Branch at Houston	101,641
University of Texas Dental School at San Antonio	34,012
Tufts University School of Dental Medicine	55,422
Virginia, Commonwealth University School of Dentistry	86,034
Washington University School of Dentistry	62,025
University of Washington School of Dentistry	74,630
West Virginia University School of Dentistry	71,028
	$ 4,000,000

The Robert Wood Johnson Foundation
Summary of Grants
For the Year Ended December 31, 1972
Schedule B—Medical Student Aid Program

Institution	Amount
University of Alabama School of Medicine	$ 94,967
Albany Medical College of Union University	64,821
University of Arizona College of Medicine	71,281
University of Arkansas School of Medicine	132,865
Baylor College of Medicine	94,536
Boston University School of Medicine	85,062
Bowman Gray School of Medicine, Wake Forest University	74,295
Brown University, Division of Biological and Medical Sciences	27,676
Case Western Reserve University School of Medicine	85,492
Chicago College of Osteopathic Medicine	62,237
The Chicago Medical School	56,208
University of Chicago The Pritzker School of Medicine	84,631
University of Cincinnati College of Medicine	70,850
University of Colorado School of Medicine	99,704
Columbia University, College of Physicians and Surgeons	96,690
University of Connecticut Health Center, Yale University School of Medicine	54,485
Cornell University Medical College	73,003
Creighton University School of Medicine	74,295
Dartmouth Medical School	37,150
Des Moines College of Osteopathic Medicine and Surgery	68,266
Duke University School of Medicine	86,354
Albert Einstein College of Medicine	81,186
Emory University School of Medicine	84,631
University of Florida College of Medicine	66,113
Medical College of Georgia	131,142
George Washington University Medical Center	78,171
Georgetown University School of Medicine	84,631
Hahnemann Medical College and Hospital	74,726
Harvard Medical School	122,098
University of Hawaii School of Medicine	32,413
Howard University College of Medicine	189,712
University of Illinois College of Medicine	136,310
Indiana University School of Medicine	169,902
University of Iowa College of Medicine	181,530
Jefferson Medical College	107,025
Johns Hopkins University School of Medicine	88,507

Kansas City College of Osteopathic Medicine	$ 96,259
University of Kansas School of Medicine	130,281
University of Kentucky School of Medicine	114,347
Kirksville College of Osteopathic Medicine	112,193
Loma Linda University School of Medicine	91,952
Louisiana State University School of Medicine, New Orleans	80,755
Louisiana State University School of Medicine, Shreveport	38,873
University of Louisville School of Medicine	111,763
Loyola University of Chicago Stritch School of Medicine	77,310
University of Maryland School of Medicine	88,938
University of Massachusetts Medical School	27,245
Mayo Medical School	25,100
Meharry Medical College	161,719
University of Miami School of Medicine	73,865
University of Michigan Medical School	139,756
Michigan State University College of Human Medicine	76,018
Michigan State University College of Osteopathic Medicine	28,106
Milton S. Hershey Medical Center, Pennsylvania State University	63,098
University of Minnesota, Duluth, School of Medicine	25,100
University of Minnesota Medical School, Minneapolis	184,975
University of Mississippi School of Medicine	141,909
University of Missouri, Columbia, School of Medicine	98,843
University of Missouri, Kansas City, School of Medicine	27,676
Mt. Sinai School of Medicine, City University of New York	62,667
University of Nebraska College of Medicine	147,507
University of Nevada School of Medical Sciences	28,106
College of Medicine and Dentistry of New Jersey, Newark	248,239
College of Medicine and Dentistry of New Jersey, Rutgers	140,189
University of New Mexico School of Medicine	85,492
New York Medical College— Flower & Fifth Avenue Hospitals	73,865
New York University School of Medicine	92,383
State University of New York at Buffalo School of Medicine	85,492
State University of New York Downstate Medical Center	102,719
State University of New York at Stony Brook School of Medicine	27,245
State University of New York Upstate Medical Center	76,018
University of North Carolina School of Medicine	94,967
University of North Dakota Medical School	53,515
Northwestern University	110,040
Medical College of Ohio at Toledo	58,791
Ohio State University College of Medicine	100,996

University of Oklahoma College of Medicine	$ 119,514
University of Oregon Medical School	89,799
Medical College of Pennsylvania	149,661
University of Pennsylvania School of Medicine	84,200
Philadelphia College of Osteopathic Medicine	63,529
University of Pittsburgh School of Medicine	86,354
University of Puerto Rico School of Medicine	108,748
University of Rochester School of Medicine and Dentistry	69,558
Rush Medical College	34,135
St. Louis University School of Medicine	79,463
University of South Alabama	25,100
Medical University of South Carolina	109,179
University of South Dakota School of Medicine	52,223
University of South Florida College of Medicine	25,092
University of Southern California School of Medicine	84,200
Southern Illinois University School of Medicine	25,100
Stanford University School of Medicine	89,368
Temple University School of Medicine	91,091
University of Tennessee College of Medicine	116,500
Texas College of Osteopathic Medicine	27,245
University of Texas Medical Branch at Galveston	130,281
University of Texas Medical School at Houston	28,968
University of Texas Medical School at San Antonio	106,164
University of Texas Southwestern Medical School	94,967
Texas Tech University School of Medicine	25,100
Tufts University School of Medicine	97,551
Tulane University School of Medicine	103,580
University of Utah College of Medicine	76,879
Vanderbilt University School of Medicine	72,142
University of Vermont College of Medicine	81,186
Medical College of Virginia	102,288
University of Virginia Medical School	90,230
Washington University School of Medicine	96,259
University of Washington School of Medicine	97,981
Wayne State University School of Medicine	102,288
West Virginia University School of Medicine	87,646
University of Wisconsin, Madison, School of Medicine	104,011
Medical College of Wisconsin	69,127
Yale University School of Medicine	76,018
	$10,000,002

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; the need to develop mechanisms for the objective analysis of public policies in health.

The Foundation will further concentrate by encouraging and supporting only those projects and programs which show promise of having significant regional and national impact, with one exception, which will be local projects in New Brunswick, New Jersey, where the Foundation was established. Through this targeted approach, the trustees and staff hope that the Foundation's work will result in tangible improvements in the health status of the people of the United States.

Grants will be awarded to many kinds of institutions with interests in health. For administrative purposes, the grants will be made to organizations and institutions, but the funding will be viewed as investments in individuals or groups of individuals who have shown an interest, commitment, and capability in working toward the solution of problems in the field of health and who thus carry forward policy and action of their organizations.

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, or the effects of environmental contamination on health. 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.

While the Foundation's funds are substantial, they are obviously not unlimited. Therefore the Foundation must select, on the basis of careful study, a limited number of projects and programs. This means that many other projects and programs of merit will not be funded—not a happy circumstance from either the Foundation or the public standpoint, but a reality of the Foundation's financial limitations.

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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