THE ROBERT WOOD JOHNSON FOUNDATION

Making a Difference

Annual Report 2003

President's Message

RISA LAVIZZO-MOUREY, M.D., M.B.A.

President and Chief Executive Officer

About 20 years ago, shortly after my husband and I relocated to Philadelphia, our daughter, who was about two years old, ran a fever for a couple of days. At first I wasn't too worried. I had recently finished my medical residency, which meant that my definition of "sick" had become pretty extreme. "Sick," to me, meant you were about to die. Not sick? Next patient, please. After being up with her most of one night, it became clear she wasn't getting better. When I woke my husband and said, "She's sick. I think we'd better go to the emergency room," he jumped out of bed and said, "OK, let's go," because he knew that I had to mean she was about to die. We headed to the emergency room, our anxiety mounting, trying not to fill our minds with a thousand "What ifs?" I had that dishevelled, frantic look you have when you've been up all night with a fussy kid.

The physician looked at my daughter, looked at me, asked some quick questions, did a cursory exam, and said, "She's fine, go home."

In formal health care-speak, this was "an absence of appropriate engagement." And it immediately established a serious lack of trust between the doctor and this patient's mother. In less formal language, I was steamed. I adopted a different approach with that emergency room doctor. I became more assertive, more intense, threw some medical terms back at her. Enough so that she called the attending physician, who ordered more tests, including a chest X-ray. What they found was that my daughter had pneumonia. Although we walked out of the hospital having gotten the appropriate tests and with the antibiotics we needed, it was not so easy to establish trust in that place and with that doctor. My husband and I talked about how another family—a family that couldn't toss back the medical lingo, a family that didn't have the confidence to question what was happening—might not have gained the attending physician's attention, might not have received that vital X-ray. I still think about those families and those children. I know how frightened we were that night, but I knew in my heart that we would get help. I could make that happen. What's exciting to me about becoming president of The Robert Wood Johnson Foundation is that, perhaps, I can help make "appropriate engagement" happen for other people, too.

ROOTS AND INFLUENCES

This is my own personal tale about the often abstract notion of access to high-quality health care, an issue in which this Foundation is deeply engaged. And having seen the system up close as a clinician, a teacher and a researcher, I'm personally committed to providing quality health care to all people equally. I am also an M.B.A., a parent and an African-American woman. I bring to this new challenge everything I've learned in these roles, plus the core value that has guided me in all of them—a strong passion for helping others. As a geriatrician versed in chronic illness who made house calls most Mondays, I understand the fears and insecurities that individuals and families feel when the health care system fails them.

Significantly, I am a product of the Foundation. I've received much of my clinical training as the result of a fellowship—I was a Robert Wood Johnson Clinical Scholar from 1984 to 1986—so I feel a lot of loyalty, that I am carrying out the Foundation's mission and have a strong personal connection to its work.

I also bring to the job a grounding and training in finance and management from my days as a Wharton graduate student and faculty member. The importance of measurement, of accountability, and of taking a disciplined approach to resource management and motivating people are all skills that I learned—and taught—in my business studies. They will guide me as I refine and recalibrate the goals, objectives and institutional brainpower of the Foundation, so ably developed over the past decade by my predecessor, Steve Schroeder. What I've found so extraordinary here is the passion and dedication of our entire staff to this Foundation's core mission to improve health and health care, to make a tangible difference in the lives of all Americans. To a physician given an exceptional opportunity to lead, this spirit is infectious.

A TROUBLING REPORT CARD

If you asked people—both experts and rank-and-file Americans—to grade health care in this country, an overwhelming percentage would hand out a D. The system is not quite failing, but it is barely passing. This is particularly troublesome given our nation's resources.

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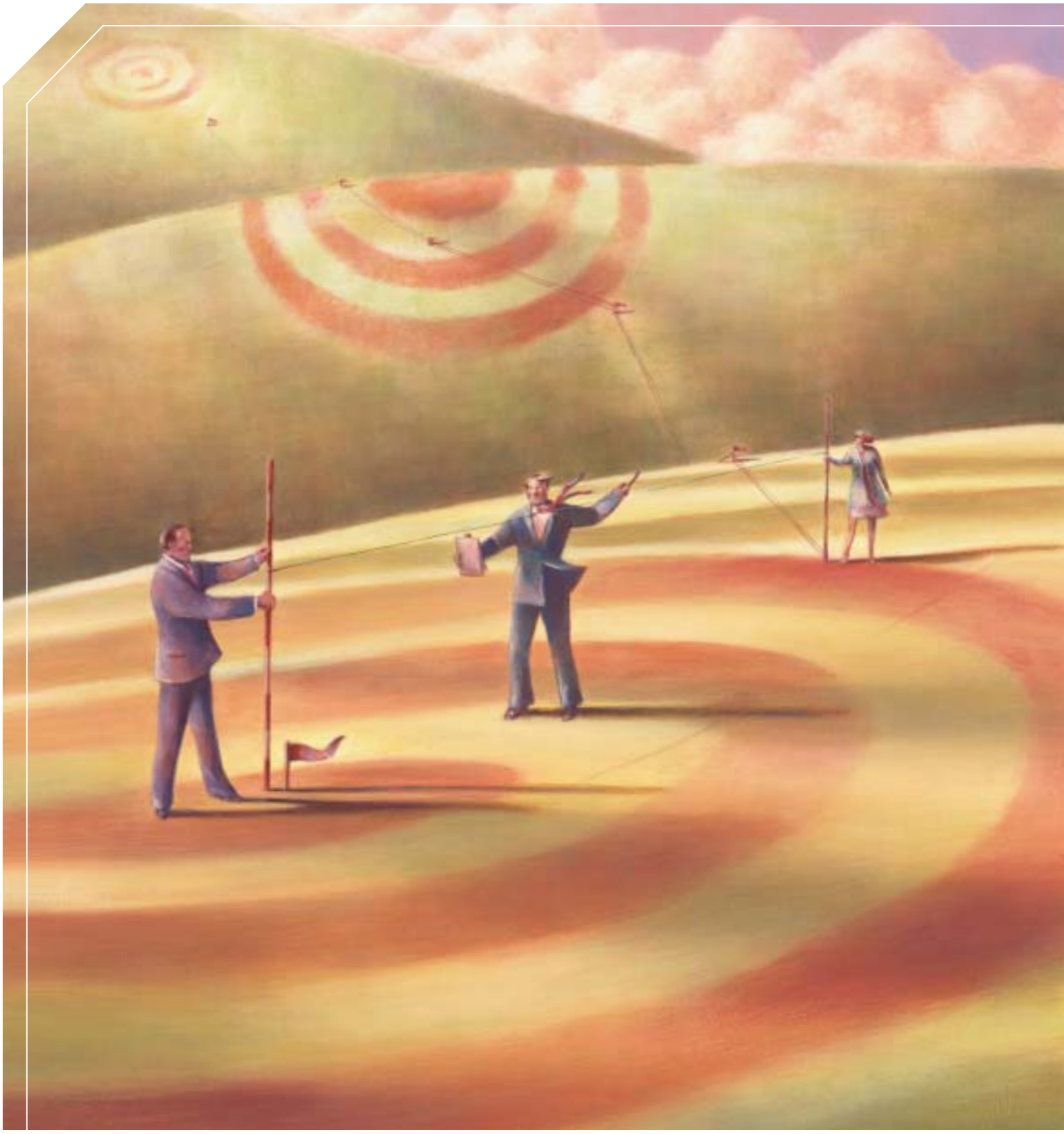

We need to become more astute in identifying problems, defining time horizons and levels of investment, and holding ourselves accountable for accomplishing the objectives that we and our grantees set out to achieve.

gap is simply intolerable. Intolerable in the care they personally receive. Intolerable in the care their loved ones receive. Intolerable in terms of the growing number of uninsured. Intolerable in the rising cost of care. Intolerable in the occurrence of medical errors. Intolerable in the seeming inability of Medicare to provide for seniors. Intolerable when loved ones die in pain, alone, without the comfort and care they need.

And what about Americans' actual health? We are barraged by news stories—confirmed by our own personal observations—that Americans are increasingly and alarmingly reaping the undesirable rewards of sedentary and overindulgent lifestyles. We are overweight. Too many of us still smoke. We drink too much. We exercise too little or not at all. We indulge in a panoply of risky behaviors.

These system problems and these personal behavior choices are like two massive freight trains speeding toward each other, and we may not be able to deal in any kind of just and humane way with the aftermath of their seemingly inevitable crash. Our challenge is to try to prevent that train wreck.

THE FOUR PORTFOLIOS

Our four goals focus on access to care, chronic conditions, community health, and substance abuse. All of them include elements that address both system change and personal behavior. They can be pursued in various ways. Most recently, we have implemented a new defining framework through which our grantmaking will operate. It is a formal construct that acknowledges the different grantmaking techniques and styles employed at the Foundation, and helps us harness these varied approaches more effectively and hold ourselves even more accountable for the private funds of which we are stewards for the public's benefit. That construct clusters our investments into portfolios. Going forward, the Foundation's grantmaking will fall into the following portfolios:

Targeted—Achieving specific improvements, in specified time frames, in nine issue areas: health care coverage, quality care, disparities in care, end-of-life care, nursing, tobacco control, addiction prevention and treatment, childhood obesity, and public health. A majority of our grantmaking is in this portfolio.

Vulnerable Populations—Identifying and fostering new and effective ways to deliver services at the community level to our most vulnerable populations, in efforts such as *Faith in Action* and our *Local Initiative Funding Partners Program*.

Human Capital—Improving the quality of the workforce and developing the leadership essential to improving health and health care. Many long-standing training programs—such as *Robert Wood Johnson Clinical Scholars, Robert Wood Johnson Health & Society Scholars,* and *Robert Wood Johnson Health Policy Fellowships*—are in this portfolio.

Pioneer—Seeking innovative, breakthrough ideas and approaches that may change the fields of health and health care.

The problems we face are national in scope, so even with our significant financial and human resources, we need to become more astute in identifying problems, defining time horizons and levels of investment, and holding ourselves accountable for accomplishing the objectives that we and our grantees set out to achieve. Our goal is to make a difference in your lifetime, and this framework will help us do that.

WHAT WILL CHANGE—AND WHAT WON'T

Under my presidency, I expect no radical departures from the past—in other words, evolutionary, not revolutionary change. We will focus on fewer issues, bringing more integrated strategies to a highly targeted set of program priorities. We will be looking two steps down the line in order to increase the chances that our grant dollars are paying off. We will put great emphasis on achieving and measuring concrete results. Grantees will find a much greater concentration on outcomes that signal systemic improvements, effect real social change, and bring discernible improvements to people's lives.

Over the past 30 years, this Foundation has touched the lives—and careers—of millions of Americans. But our nation continues to need large-scale momentum to bring about demonstrable improvements in our weakened health care and public health systems. The Foundation needs to harness and focus our enormous potential to garner public support to broaden and deepen our impact.

The Robert Wood Johnson Foundation has been an innovator and leader in the way we communicate our goals, our programs and, of course, our grantees' myriad accomplishments. I want our communications to become even better. We need to be more transparent about how we do our work, what we expect from grantees (and of ourselves), and how we evaluate our grant results. I want to make our key initiatives a constant part of the national debate and to find new venues to talk about the core issues that will determine the future health of all Americans.

What will *not* change is our Board's vision, compassion and dedication—the legacy of our founder, Robert Wood Johnson—and the energy and resourcefulness of our staff and grantees in implementing that vision. While we are proud of what has been accomplished and look forward to the successes that we believe lie ahead, we are humbled by the magnitude of the task. We will continue to "work smart," but we are neither omniscient nor omnipotent. The sea we seek to navigate is wide and deep and, even with the considerable financial and intellectual assets at our command, our boat is still quite small.

NEW CORE ISSUES

Many items in the portfolios will seem familiar issues for RWJF. Here's my thinking about some of the newer issues that will be at the top of our agenda in the next few years.

Nursing: When we think about the future of health care, it will be the nurses and other front-line workers who will be on the leading edge of change. Over the next decade, we are committed to a thorough re-examination of the ways in which nurses interact with other health care providers. In the hospital setting, particularly, these relationships have to be retooled to adapt to shifting circumstances that include:

- An aging population with many complex chronic conditions.
- A hospital nursing workforce whose average age is 45.
- A disconnect between the existing workforce and an increasingly diverse patient base.
- A lack of professional autonomy coupled with institutional cultures that inhibit nurses from pressing for needed changes.

The nursing profession is in extremis, and our nursing initiatives, which will focus on improving the hospital work environment, will be at the core of our increased emphasis on health care quality.

Quality: We must redefine what "quality health care" means to Americans. All too often, the term "quality" defaults to simplistic notions of more-is-better,

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get-it-when-you-want-it, and having-the-latest-and-best-amenities. People almost never define quality care as timely, efficient, cost-effective or patient-centered. When I think back to that night in the emergency room with my daughter, what we wanted was timely care, not fancy waiting rooms or the newest, most expensive antibiotics. Current thinking seems to have locked providers into a permanent growth cycle, adding new services, new wings, whole new specialty hospitals. Inevitably costs go up. But challenge administrators on the *quality* of these new services, and you learn that they perceive quality initiatives as an expensive "add-on." My fervent wish is that 10 years from now people will understand we can't afford *anything other than* quality care. It's the only kind of care that we should accept, that should be delivered, and that should be reimbursed. And what does quality care look like? It's centered on the patient and family, based on the best clinical evidence, cost-effective and systems-minded—meaning that all disciplines and institutions work cooperatively. This paradigm is almost infuriatingly logical, but it requires nothing short of a revolutionary change in mind-set, which we hope to help bring about.

Childhood Obesity: America's social and cultural environment should make it easier for kids to eat right and be active. In our programming, we will focus on children because, in terms of this problem, they are the most vulnerable group in our society—the least autonomous, yet the target of a continuous barrage of unhealthy temptations. Recently, the *New York Times* reported that if the present trajectory in kids' eating habits holds, their generation is destined to have a shorter life span than adults have today. Such a regression is unconscionable.

Even people who believe that addressing children's obesity is primarily their parents' responsibility acknowledge how hard a job that is in the current environment. I look back and realize how fortunate I was in raising my son and daughter. I was blessed with financial resources that many parents don't have, and my children attended a school that emphasized healthy foods and physical activity as a regular part of the day. How unusual that is becoming! Exposed to high-calorie non-nutritious foods, television, video games and neighborhoods that are not walkable, our children's bodies are like strangers in a strange land. The world has changed but their physiology has not. The challenge for the Foundation is to help communities create environments that are healthier for kids and to help parents encourage the right choices.

Vulnerable Populations: Too many people fall through the cracks of today's health care system. Sometimes because of age. Sometimes the problem is poverty. Sometimes it's culture or ethnicity. Sometimes it's race. "Vulnerable populations" cannot be simply defined. But what links vulnerable people together is the difficulty they have in navigating our nation's health care system or in protecting their own health. Typically, they need services from a number of providers and, because these component parts of our "system" often are uncoordinated, the likelihood of both redundant services and overlooked needs is high. A key challenge here for the Foundation is to locate the gaps in care, and develop new service delivery models—something we have considerable experience in doing. We need to find effective models that can be adapted to work at the community level, rather than waiting for a probably less effective, less flexible one-size-fits-all national solution.

Disparities: Various racial and ethnic groups experience the United States health care system differently, regardless of income, education levels, or location, as my opening tale helps illustrate. We can define and approach this problem in several ways. One that I believe will be particularly effective is to support

efforts to develop evidence-based protocols for specific procedures, recognizing that care will never be completely uniform because it has to account for individual differences and preferences. Quick progress may be possible in some specific disease areas—cardiovascular conditions, for example—because the evidence of poor outcomes due to disparities in care is compelling.

PROGRAM CHANGES

One of the great lessons my predecessor Steve Schroeder passed on to me and our foundation colleagues can be found in his 2001 Annual Report message. It's the line from the Kenny Rogers tune, *The Gambler*: "Know when to hold 'em; know when to fold 'em." Foundations rarely support enterprises, or even fields, in perpetuity. There are always new fields to plow, new ideas to reach for, new players with new objectives and visions. The hard part, as Steve so aptly noted, is determining when to exit a field. We don't always get it right—it's hard to know when you've reached the tipping point, except in hindsight. In recent years, we've had some notable successes—in groundbreaking work on helping patients, families and providers deal with decision-making and care near the end of life, and in reducing the harm caused by substance abuse, particularly tobacco use.

We at The Robert Wood Johnson Foundation take pride in knowing that we've helped to build these fields and have contributed to the successes achieved by the many dedicated people with whom we're privileged to have been associated. Indeed, it is partly because of these successes that we feel prepared to move on to other critical health challenges—childhood obesity, disparities in care and hospital nursing. In the short run, we will continue to meet our past commitments to fund both prevention efforts related to tobacco and to other substances, like alcohol and illegal drugs, *and* end-of-life issues— for, to be sure, there are still considerable hills to climb before unalloyed triumph in those fields can be declared. But we believe that the successes that have been achieved can be sustained with some additional support from The Robert Wood Johnson Foundation and with the continued robust efforts of our partners and other innovators in these fields.

GOOD PEOPLE, GOOD IDEAS

The prospects for The Robert Wood Johnson Foundation are bright. Building on the impressive legacies of my three predecessors, I am confident that our dedicated staff, grantees and funding partners truly can help to improve the health and health care of people in this country. We do this simply through investing in good people and good ideas. Throughout the various changes outlined in this message, this remains a constant. When you read the tribute to Terrance Keenan that follows, you will understand more fully what I mean and how I know that our staff, following Terry's example, will continue to find the good people and good ideas that the Foundation will be proud to support.

Risa Lavizzo-Mourey, M.D., M.B.A.

President and Chief Executive Officer

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Honoring the Contributions of TERRANCE KEENAN

Leadership Excellence Dedication

Sometimes, an organization gets lucky. Sometimes, an extraordinarily talented person emerges from its ranks and, simply by following his instincts, comes to personify what the organization is striving to be. Sometimes, that person contributes for a long time, cooking up a seemingly endless string of inventive ideas, leading by marvelous, inspiring example, and becoming beloved inside the organization and out. And sometimes, if it's lucky, the organization has a chance to offer a public thanks. The Robert Wood Johnson Foundation got lucky with Terrance Keenan.

In December, Terrance, or Terry as friends and colleagues know him, formally retired from RWJF after 31 years of service, but he remains a formidable intellectual presence, inspiration and contributor. He was with the Foundation from the beginning and, during his tenure, he helped expand the Foundation from a fledgling organization to an influential leader in improving the health and health care of all Americans.

"He was an ambassador at large for the world of philanthropy," said Edward Robbins, former director of RWJF's Office of Proposal Management. "Anyone who ever came into contact with Terry felt differently about philanthropy afterward. He cares about people, particularly those who are downtrodden, and that really came across."

Within RWJF, Terry's influence can be judged by the number of once-controversial ideas that he championed and eventually brought into the mainstream. His longtime friend and colleague Frank Karel, RWJF's former vice president for communications, offers a particularly Keenansian insight.

When RWJF first started making grants nationwide, Karel said, "We would parachute into a community, give some money to start something, and then when our three or four years of support were up, the people we had funded would start knocking on doors looking for more money. Some of the small local foundations were getting upset." Terry's solution? A program that identified proposals from local and community foundations that meshed with RWJF guidelines and offered matching money up to $500,000. The *Local Initiative Funding Partners Program* that Terry conceived is now properly recognized as one of RWJF's signature efforts. "It was an absolute stroke of genius," Karel said.

Similarly, Terry saw nurses as skilled medical professionals when most of the medical community viewed them as support staff. "He single-handedly encouraged the Foundation to become interested in nursing's contributions to primary care," said Rheba de Tornyay, dean and professor emeritus at the University of Washington School of Nursing in Seattle and trustee emeritus of the Foundation.

Often a "love-hate feeling" simmers between grantees and the foundations that fund them—and there can be mutterings about arrogance and lack of sensitivity and responsiveness. Not so with Terry. Regarded as a consummate grantmaker, he has been especially appreciated by novice grant applicants because he worked hardest for them. If they had the germ of an idea, he was always willing to take the time and do the work to help them develop their thoughts and their plan.

In many ways, his modus operandi was an exact match with the Foundation's Guiding Principles: Always remembering that the organization represents a public trust; recognizing the primacy of new ideas and innovation; and demanding of himself and others the highest professional performance.

But Terry's greatest legacy may be the example he set for his peers and colleagues, said Steven Schroeder, former president of RWJF: "People have told me that he's their role model. They'd like to grow up to be like Terry Keenan."

GOAL SINCE: **1972**

NUMBER OF GRANTS AND CONTRACTS AWARDED IN 2003: **198**

DOLLAR AMOUNT OF GRANTS AND CONTRACTS AWARDED IN 2003: **$76,532,687**

Assuring Access to Care

Securing health care coverage for all Americans remains a central focus of the Foundation's work, and for good reason. The latest figures from the U.S. Census Bureau show that nearly 44 million Americans, including 8.5 million children, are without health coverage. In 2002, the number of uninsured increased by more than 2 million, the largest one-year increase in a decade.

While the latest figures are grim, this year's may be worse. Fast-rising health care costs continue to undermine the ability of working families, individuals, businesses and state governments to purchase health insurance. To make matters worse, severe budget constraints are causing states to curb spending on Medicaid and on programs that cover children from low-income families.

To reverse this disturbing trend, the Foundation is leading an unprecedented effort to highlight the challenges of the uninsured; foster a constructive, nonpartisan, national discussion on the uninsured informed by state-of-the-art research; and focus attention on a wide array of possible solutions.

The first Cover the Uninsured Week, co-chaired by former Presidents Gerald Ford and Jimmy Carter, brought home the message that millions of Americans—most of them from working families—struggle daily with serious threats to their health because they are uninsured. The campaign also underscored the immediacy of this issue, because virtually anyone can lose their health care coverage.

Between March 10 and 16, 2003, more than 800 national and local organizations and tens of thousands of Americans participated in nearly 900 public events—town hall meetings, interfaith prayer breakfasts, health fairs, business and labor events, and teach-ins at medical and nursing schools in all 50 states and the District of Columbia. These local events were coordinated with national and local advertising and the release of several new research studies.

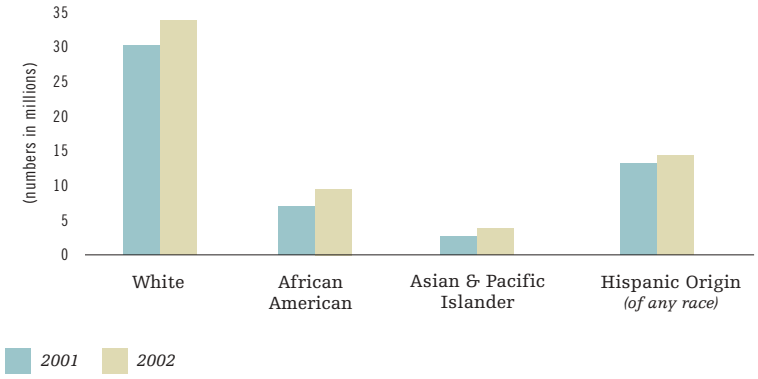
In all, the Week's events generated more than 3,000 news stories that reached a cumulative potential audience of 380 million. Most importantly, though, polling showed that the Week's events contributed to a better understanding of the problem by a large number of Americans.

To effect positive social change, policy-makers need good information. The Foundation is committed to supporting analytically sound research. To that end, the Foundation asked the Lewin Group to produce estimates of the cost and coverage implications of 10 policy proposals to expand health care coverage. These proposals, developed by a diverse group of analysts from across the policy spectrum, ranged from individual tax credits to a publicly financed program of guaranteed universal coverage.

The estimates showed that significant progress can be achieved in covering the uninsured through a variety of approaches. National health spending would increase modestly, but the distribution of health care costs and savings among families, employers and government would shift significantly. This analysis was presented at a Capitol Hill briefing in October 2003 before an audience of congressional and executive branch staff and leaders of major national organizations.

Other Foundation-funded research on coverage released in 2003 included more than 50 reports from the Economic Research Initiative on the Uninsured at the University of Michigan, the Urban Institute and the Center for Studying Health System Change. These studies looked at why so many people are uninsured in America and what the lack of insurance means to them. The topics included the states' fiscal crises; coverage of children in immigrant families; widowhood and divorce among mid-life women and their relationship to loss of health insurance; and unequal access to prescription drugs for African-American Medicare beneficiaries. In addition, the State Health Access Data Assistance Center at the University of Minnesota provided extensive technical assistance to states to help them produce estimates of the uninsured.

Persons Without Health Insurance Coverage for the Entire Year by Race and Ethnicity, 2001 and 2002



Source: Current Population Survey, 2002 and 2003 Annual Social and Economic Supplements. Health Insurance Coverage in the United States. *U.S. Census Bureau.* Available at: *www.census.gov/prod/2003pubs/p60-223.pdf* [2002].

COMMUNITIES IN CHARGE: Financing and Delivering Health Care to the Uninsured

A program for communities to improve access to care for low-income, uninsured individuals by rethinking the organization and financing of local care delivery.

As part of its continuing effort to help time-pressed policy-makers stay up-to-date on the latest reports and findings, the Foundation's Synthesis Project released in 2003 the new policy brief, *Tax Subsidies for Private Health Insurance: Who Currently Benefits and What Are the Implications for Policy?* This report addresses how the federal government subsidizes private health insurance, who benefits from current tax subsidies for employer-sponsored insurance, and the advantages and disadvantages of the current approach.

Also in 2003, the Institute of Medicine released its fourth and fifth reports in a series of six, documenting the consequences of being uninsured in the United States. The fourth report, *A Shared Destiny: Community Effects of Uninsurance,* found that a community's high uninsurance rate has adverse consequences for the community's health care institutions and providers, reducing access to clinic-based primary care, specialty services and hospital-based care. In its fifth report, *Hidden Costs, Value Lost: Uninsurance in America,* the Institute found that the economic benefit of providing health care coverage to all would almost certainly outweigh the costs.

Other Foundation programs focused on the uninsured continued to make significant progress. Through the *Covering Kids and Families*® program and its Back-to-School campaign, the Foundation is helping to increase the participation of eligible children and adults in Medicaid, the State Children's Health Insurance Program (SCHIP) and other public health coverage programs.

The Foundation also continues to work with the Healthcare Leadership Council (HLC), an organization of CEOs of major health care companies. The Foundation has supported the HLC's pilot program, an outreach effort to small business owners coping with the challenges of providing their employees with health care coverage. The HLC informs business owners about steps they can take to either obtain or retain health care coverage for their employees.

While states struggle to fund their health coverage programs, the Foundation's *State Coverage Initiatives* works with states to improve the availability and affordability of public health coverage. Using a similar approach, *Supporting Families After Welfare Reform* helps states and large counties solve bureaucratic problems that create barriers for low-income families applying for Medicaid and SCHIP.

At the local level, the Foundation's *Communities in Charge* initiative helps communities develop innovative health care delivery programs for improving access to quality care for their uninsured residents. Fourteen communities across the country are participating in this program.

In the coming year, the Foundation plans to continue its work on this important issue, with the ultimate goal of securing health coverage for all Americans.

GOAL SINCE: 1971

NUMBER OF GRANTS AND CONTRACTS AWARDED IN 2003: 291

DOLLAR AMOUNT OF GRANTS AND CONTRACTS AWARDED IN 2003: $63,325,776

Improving Chronic Health Conditions

Americans are living longer, but with chronic conditions—such as diabetes, hypertension, heart disease and asthma—that require ongoing, high-quality health care. Yet new research reveals serious gaps in our system, in both the quality of care and how that care is provided to people in racial and ethnic minority groups.

A landmark RAND Health study initiated by RWJF found that widespread deficiencies in health care quality pose "serious threats to the health of the American public" that could contribute to thousands of preventable deaths each year. For example, only 45 percent of the studied patients who had suffered heart attacks received drugs that could cut their risk of death by more than 20 percent. The RAND findings, published in the *New England Journal of Medicine*, shattered the conventional wisdom about the exceptional quality of health care in the United States.

The Foundation addresses the quality dilemma on several fronts. RWJF is joining with providers, purchasers and others to establish standards for measuring health care quality, develop a framework for reporting those measures publicly, and create incentives for improving care.

With the Commonwealth Fund and the National Quality Forum, RWJF is seeking to achieve consensus across the health care system on a standard set of outpatient quality performance measures and to improve existing measures and data collection methods.

The Leapfrog Group, with Foundation support, is exploring one model for reporting those measures publicly, encouraging hospitals to report their quality measures on a voluntary basis. Leapfrog also serves as the national program office for *Rewarding Results*, funded jointly by RWJF and the California HealthCare Foundation to encourage health plans and purchasers to provide incentives that reward high-quality health care. One *Rewarding Results* project, Bridges to Excellence, is working in three cities—Boston, Louisville and Cincinnati—to test the effectiveness of incentives to improve the quality of care.

The ever-expanding use of the Internet, combined with emerging information technologies, also offers new opportunities for enhancing the quality of care. The Foundation's *Health e-Technologies* initiative has awarded 19 grants to assess a range of projects, including Web-based weight management programs and one using e-mail in the workplace to encourage healthy behavior.

Similarly, *Prescription for Health*, a program co-sponsored by the Foundation, the federal Agency for Healthcare Research and Quality, and the National Institutes of Health, is field-testing promising models for improving everyday clinical practice among 17 primary care practice-based research networks.

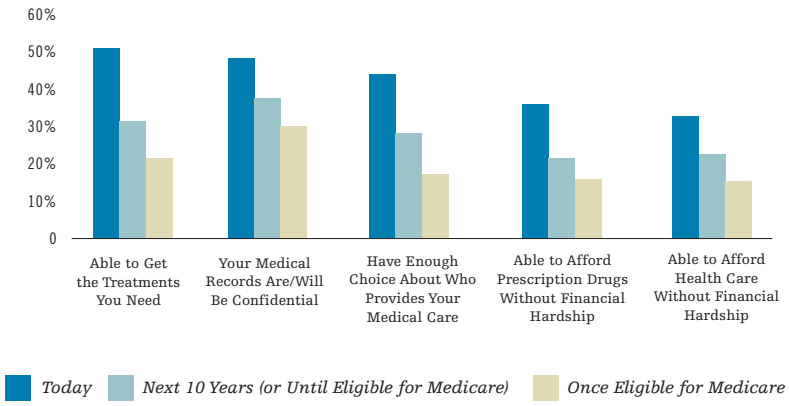
The quality of care received by the frail elderly and others with chronic conditions depends on the competence and dedication of their caregivers. *Better Jobs, Better Care*, a program funded jointly by the Foundation and the Atlantic Philanthropies, seeks to improve recruitment and retention of high-quality nursing assistants, home health aides, personal care attendants and other caregivers working in long-term care settings. In 2003, the program funded five projects in Pennsylvania, Vermont, Iowa, North Carolina and Oregon to expand and promote innovative workforce policies and practices.

Our health care system must provide high-quality care to *all* Americans. The Institute of Medicine has documented that persons from racial and ethnic minority groups receive lower-quality health care than whites, even when their insurance status, income, age and severity of condition are comparable.

We still know too little about how patients from diverse racial and ethnic backgrounds receive care, especially for specific chronic conditions such as diabetes, cardiac disease and kidney disease. Having and applying such information is an essential first step toward reducing the unconscionable racial and ethnic disparities that plague our health care systems.

To that end, systems need to track the race or ethnicity of patients receiving care. Because this approach raises potentially sensitive issues, the Foundation in 2003 supported research, conducted by the American Association of Health Plans (now AAHP/HIAA) and Public Opinion Strategies, to better understand the views of health plans

Extremely or Very Confident in Certain Aspects of Health Care Today, in the Next 10 Years, and Once Eligible for Medicare, 2003



Source: Health Confidence Survey. *Employee Benefit Research Institute* and *Mathew Greenwald & Associates, Inc.* Available at: *www.ebri.org/hcs/2003/03hcsfs1.pdf* [2003].

FAITH IN ACTION®

A program that brings together volunteers of many faiths to help people with long-term health needs or disabilities maintain their independence by providing assistance with daily activities.

and diverse consumers, identify potential barriers to collecting needed information, and establish safeguards for gathering patients' racial and ethnic information.

The Foundation's work to address health care disparities builds on existing programs aimed at improving health care for an increasingly diverse American public. For example, research has shown that many patients who are not proficient in English often delay seeking the health care they need. *Hablamos Juntos*, the RWJF national program to reduce language barriers for Latino patients, awarded 10 demonstration grants in 2003. Grantees, ranging from major hospital systems in Virginia and California to a community health plan in Providence, R.I., are working to develop affordable models for health care systems to increase language access for Latino patients, emphasizing skilled translator services and high-quality bilingual signage and health education materials. Communicating and connecting with patients is a key factor in providing high-quality health care. Thus, the Foundation is supporting a group of *Local Initiative Funding Partners Program* grantees working to make health services more culturally sensitive. In Cleveland, El Barrio, a social service agency, is establishing a health care careers center to increase the number of Hispanic community residents entering nursing and related health careers.

Recent public attention to issues of care at the end of life have highlighted the long-standing Foundation focus on a serious concern for Americans and their health care systems. During the past decade, the Foundation has funded nearly $160 million in grants to educate physicians and nurses on palliative care, improve end-of-life care in hospitals and hospices, and change the way that health care professionals and the public think about and care for people at the end of life. This year, the Foundation took stock of its active end-of-life grants to determine which programs are firmly established and which may need further support to complete their work or to make the transition to other funding.

• Foundation-funded institutional change efforts continue to be led by the *Center to Advance Palliative Care* at Mount Sinai School of Medicine and Promoting Palliative Care Excellence in Intensive Care at the University of Montana College of Arts and Sciences.

• The highly effective *Community-State Partnerships to Improve End-of-Life Care* program closed in 2003. Its legacy of public engagement continues with Rallying Points, now working with 360 state and local coalitions nationwide.

• *Last Acts*® has created a new entity—Last Acts Partnership—that will increase its consumer education and advocacy efforts, working with and through more than 1,200 organizational partners.

The Foundation expects to complete its investments in improving end-of-life care within the next few years. The work accomplished during this past decade has transformed both public dialogue and public policy on end-of-life care. We are confident this progress will continue, and will remain vigilant to ensure that it does.

GOAL SINCE: **2001**

NUMBER OF GRANTS AND CONTRACTS AWARDED IN 2003: **163**

DOLLAR AMOUNT OF GRANTS AND CONTRACTS AWARDED IN 2003: **$61,265,028**

Promoting Health & Well-Being

The terms "health" and "well-being" mean many things, among them vigor and vitality, freedom from disease, peace of mind and a sense of feeling safe and secure. Ideally, our public health system should promote all of these dimensions.

But that job became much tougher after the terrorist strikes on September 11, 2001, and the anthrax attacks that soon followed. Suddenly, the nation's public health system was thrust into the national spotlight. In response, the federal government invested $2.4 billion in the system to improve bioterrorism preparedness.

This dramatic shift in focus raises serious questions about balancing competing public health priorities. Does strengthening the nation's capacity to protect against bioterrorism enhance or undermine its ability to handle emerging infectious diseases, such as SARS and West Nile virus, or to address increasing rates of chronic conditions, such as obesity, that affect tens of millions of Americans?

To ensure that the country has a viable public health system capable of protecting the public from a wide range of threats, the Foundation continues to focus its efforts across several dimensions of health.

In the last decade, the Foundation has concentrated much of its work on improving public health leadership, information infrastructure and advocacy. In 2003, the Foundation renewed the successful *State Health Leadership Initiative* (SHLI), which trains newly appointed state health officers to manage their complex departments, form better relationships with their state's chief elected legislators and the media, and secure improved results from the public health programs they lead. SHLI alumni who went through the program several years ago reported that the training they received helped prepare them to respond to the terrorist attacks of 2001.

Keeping public health issues in the spotlight is an essential step in improving the system. In an effort to focus public and policy-maker attention on critical public health needs in 2003, the Foundation supported the release of three reports by the Trust for America's Health:

(1) One report focused on the state of public health laboratories and found they were overwhelmed and unprepared to deal with a biochemical terrorist attack.

(2) Another report examined states' cancer tracking efforts and recommended ways states could improve prevention and early detection efforts.

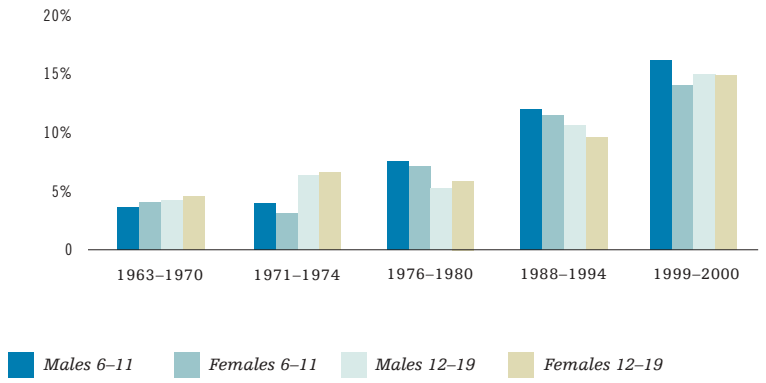
(3) A third report asked whether—two years after 9/11—states were any better prepared to protect residents from bioterrorism and other public health threats. The report found that while some progress has been made, much remains to be done.

The three reports and the media coverage that followed helped stakeholders advocate for a stronger public health system.

While the nation is grappling with external threats to public health, there also is a critical need to focus on what our current Surgeon General, Richard Carmona, refers to as "the terror within"—the epidemic of obesity. The Foundation in 2003 focused on learning more about the causes, potential solutions and courses of action it might pursue to help halt the rapid increase in obesity among children. Today there are nearly twice as many overweight kids (ages 6 to 11) and almost three times as many adolescents (ages 12 to 19) as there were in 1980.

The Foundation supported the development of a newspaper series, *The Shape We're In,* produced by the independent Public Access Journalism group. *The Shape We're In,* which ran in 77 newspapers and reached 5.8 million readers, explored the many factors that contribute to the obesity epidemic and highlighted innovative solutions. Readers learned how doctors are preventing and treating obesity, how school physical

Percentage of Overweight Children and Teens by Age



Source: The Burden of Chronic Disease and the Future of Public Health. *Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion.* Available at: *www.cdc.gov/nccdphp/burden_pres/bcd_29.htm* [2003].

YOUNG EPIDEMIOLOGY SCHOLARS (YES)

A program to heighten awareness of epidemiology and public health among high school students and teachers.

education has changed to provide kids with lifelong skills for staying active, and how residents are making their communities more walkable.

Because schools are an important setting for fighting childhood obesity, the Foundation conducted two national polls of parents and teachers. Final results showed overwhelming agreement among parents and teachers on the role schools should play in stopping the epidemic, including replacing the contents of school vending machines with healthy foods and drinks, and requiring students to take physical education every day, in every grade level.

The Foundation also raised awareness of the connection between a community's design and public health. In August, it supported the joint release of special issues of the *American Journal of Health Promotion* (AJHP) and the *American Journal of Public Health* (AJPH) on the links between the built environment and health. The Foundation funded the lead study, *Relationship Between Urban Sprawl and Physical Activity, Obesity, and Morbidity,* published in AJPH. Findings showed that, as sprawl increases, so does the likelihood that residents will be overweight or have high blood pressure.

To counter the effects of sprawl and provide better opportunities for physical activity for all Americans, the Foundation continued to promote and support active living, a way of life that incorporates physical activity into daily routines. *Active Living by Design,* a $16.5-million national program, announced 25 community partnerships across the nation. Each will receive up to $200,000 over five years to address community design, land use, transportation, architecture, recreation and other issues that influence healthier lifestyles.

Smaller, community-based programs also continue to play a key role in the Foundation's work to promote health and well-being. The Foundation has funded a range of community interventions to encourage healthy lifestyles among children and families. Students Run L.A., a school-based volunteer mentoring program that provides at-risk teens with the training and life skills needed to complete the Los Angeles marathon, will design a toolkit that helps communities nationwide develop similar initiatives. In New Jersey, Saint Peter's University Hospital joined with New Brunswick elementary schools to encourage kids to "eat healthy" and participate in regular physical activity. Nurses, dieticians and physicians are providing children and their parents with the knowledge and tools they need for lifelong success in weight management.

The Foundation's work has made it clear that efforts to strengthen the country's public health system are needed at all levels, ranging from national leadership to state-run programs, community initiatives and local awareness campaigns.

GOAL SINCE: **1991**

NUMBER OF GRANTS AND CONTRACTS AWARDED IN 2003: **131**

DOLLAR AMOUNT OF GRANTS AND CONTRACTS AWARDED IN 2003: **$71,386,440**

Reducing Substance Abuse

Addictions to drugs, alcohol and tobacco inflict devastating consequences on millions of Americans and their families. More than 600,000 emergency department admissions per year are attributed to abuse of either alcohol or drugs. An estimated 22 million Americans age 12 and older—or 9.4 percent of the total population—were classified with substance dependence or abuse in the 2002 National Household Survey on Drug Use and Health. For youths ages 12 to 17, the rate of substance dependence or abuse was 8.9 percent.

Prevention and treatment are key to combating addiction. To that end, the Foundation's comprehensive array of programming is aimed at reducing underage drinking and drug use and at educating the public and key stakeholders about best practices in addiction prevention. New programming focuses on increasing the availability and quality of addiction treatment services.

Helping the millions of Americans struggling with addiction get high-quality treatment is an essential priority for the Foundation. The *Paths to Recovery* program aims at improving admissions and retention in treatment programs. From Acadia Hospital in Bangor, Maine, to the Perinatal Treatment Services Center in Spokane, Wash., *Paths to Recovery* helps 10 local treatment providers improve efficiency and keep patients engaged in recovery.

Unfortunately, resources for treatment are scarce, and many states are struggling to cope with spiraling Medicaid costs and limited revenues. The *Resources for Recovery* program, working with 15 state agencies, develops and puts into practice innovative financial management techniques for meeting the growing demand for longer-term drug and alcohol addiction treatment. Through *Resources for Recovery,* senior state officials devised plans for meeting treatment demands without jeopardizing state budgets, focusing on ways to broaden and strengthen Medicaid services, processes for pooling funding for treatment across purchasers, and methods for improving efficiency. If successfully applied, these techniques could redirect an estimated $1.2 billion or more in state funding to improve the quality of substance abuse treatment.

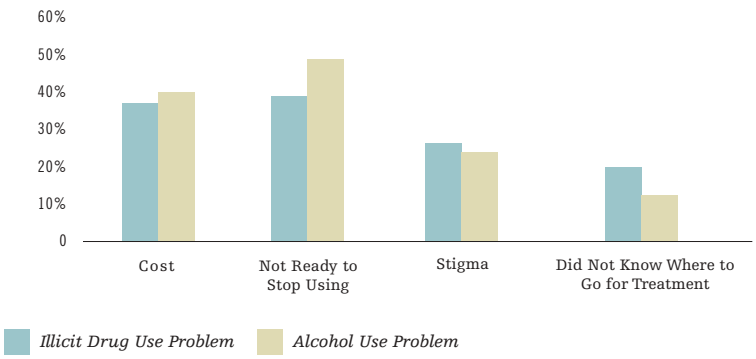
Oregon has already started using an innovative approach to provide low-income people addicted to alcohol access to residential treatment programs. Since Medicaid funding cannot be used to pay for housing, Oregon officials use separate state monies to finance housing and meal costs for low-income individuals at the residential centers, while using Medicaid funds to pay for the clinical treatment they receive there.

Reaching young people in the juvenile justice system who need substance abuse treatment is especially challenging. An estimated 63 percent of teenagers in juvenile corrections facilities do not receive needed drug or alcohol treatment, increasing the likelihood they will resume drug and alcohol use when released.

To address this problem, the Foundation's national program, *Reclaiming Futures*®, issued initial planning grants of $1 million in 2003 to each of its 10 program sites across the nation. The goal of each plan is to improve the extent and quality of treatment for drug and alcohol disorders for youths in the juvenile corrections system; establish coordinated social services for these youths; and mobilize communities to develop new opportunities in work and education for youngsters emerging from corrections facilities.

Support for treatment programs depends, in part, on how the public and policy-makers view addiction. The arts can put a human face on addiction and inspire compassion for those in recovery. "High on Life: Transcending Addiction," an exhibit at the American Visionary Arts Museum in Baltimore, showcased the works of artists in recovery and presented artistic portrayals of people handling their addictions. The *Washington Post* praised the exhibit as one of its "Top Ten Local Exhibitions" and the *Baltimore Sun* called it "ambitious, disturbing, thought-provoking and supremely compassionate."

Percentage of Persons Ages 12 or Older who Reported Different Reasons for Not Receiving Treatment for Illicit Drug Use or Alcohol Use Among Those who Perceived an Unmet Treatment Need, 2002*



* Respondents could indicate multiple reasons; thus, these response categories are not mutually exclusive.

Source: National Survey on Drug Use and Health Report. *Office of Applied Studies, Substance Abuse and Mental Health Services Administration*. Available at: *www.samhsa.gov/oas/2k3/SAnoTX/SAnoTX.pdf* [2003].

DEVELOPING LEADERSHIP IN REDUCING SUBSTANCE ABUSE

A program to provide professional growth and development for the next generation of leaders in the field of substance abuse—alcohol, tobacco and illegal drugs.

Music, too, is often the art of choice to express concerns about substance abuse. Join Together/Demand Treatment, in conjunction with SHARE, a nonprofit group based in Nashville, produced a country-western music CD called "Songs of Hope, Awareness, and Recovery for Everyone," featuring prominent musicians. The idea was conceived by a group of Nashville music industry veterans who wanted to put the venerable country music tradition of the drinking song to socially productive use. Tapping into celebrity allure and popular music formats, the songs on the CD chronicle a journey from darkness to light, from the illness and despair of drug and alcohol addictions to the strength and hope that treatment and recovery offer. The featured song, "When Love Rules the World," is an uplifting ballad performed by contributing artists. Profits from the sale of the SHARE CD are expected to top $1 million and will be used to support local treatment initiatives in the Nashville area and other Join Together/Demand Treatment activities.

Tobacco addiction is finally—and significantly—on the decline. Since 1995, tobacco use has fallen 12.6 percent among adults and more than 18 percent among youth. Nevertheless, an estimated 46.5 million adults and an estimated 4.5 million adolescents in the United States continue to smoke. The Foundation supports policy changes that reduce tobacco use through prevention and treatment, both saving and improving lives. These policies include comprehensive smoke-free air laws, tobacco tax increases, and expanded coverage of tobacco dependence treatment by government and private payers.

Foundation-supported research, such as *Bridging the Gap,* a multi-center research partnership, and the *Substance Abuse Policy Research Program,* is helping guide the tobacco control movement. Evidence shows that when cigarettes cost more, tobacco use decreases, especially among teens. This finding has prompted 31 states and the District of Columbia to increase taxes on tobacco products in the past two years.

In 2003, tobacco tax increases passed in Nevada, New Mexico and Georgia. Six states, including New York, Connecticut and Delaware, adopted clean indoor air laws. In these states and on the national level, the Foundation's *SmokeLess States*® network and grantees, including Americans for Non-Smokers Rights and the Campaign for Tobacco-Free Kids®, engaged in public education, advocacy and media campaigns.

And backed by strong evidence that smoke-free work, dining and entertainment environments promote better health *and* good business, Kids Involuntarily Inhaling Secondhand Smoke (KISS) has made inroads with state and national restaurant associations in efforts to promote the health and business benefits of going smoke-free.

Working with partners and grantees, the Foundation seeks to increase support from the public, nonprofit and private sectors to leverage the more than $100 million that RWJF will invest in tobacco control in the next five years. The Foundation will focus on targeted policy research, advocacy and strategic communications to promote policy initiatives and further reduce tobacco use.

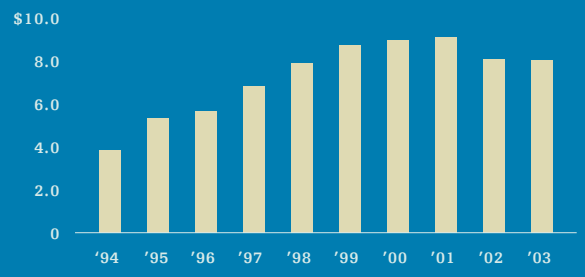
The Year in Review

	January 1–December 31, 2003
Total Assets	$7.93 billion
Total Dollar Amount of Grants and Contracts Awarded*	$316.5 million
Total Dollar Amount of Grants and Contracts Paid**	$440.94 million
Total Number of Proposals Received	5,195
Total Number of Grants and Contracts Awarded	927
Average Grant Size	$343,208

The Robert Wood Johnson Foundation Funding Highlights

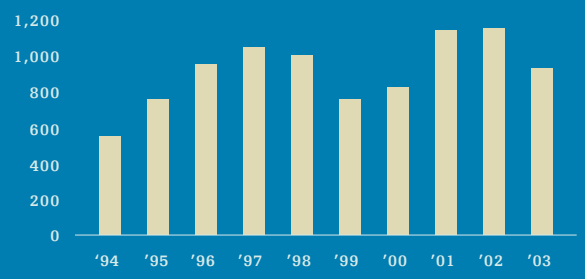
ASSETS OF THE FOUNDATION 1994–2003

(in billions)

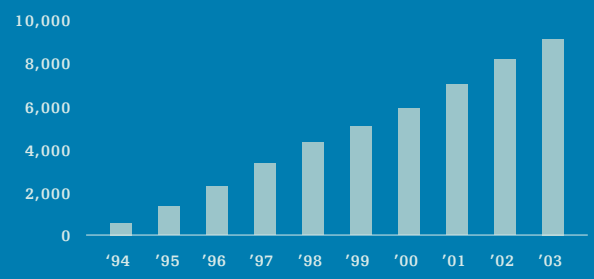


NUMBER OF GRANTS AND CONTRACTS AWARDED 1994–2003

Individual Years

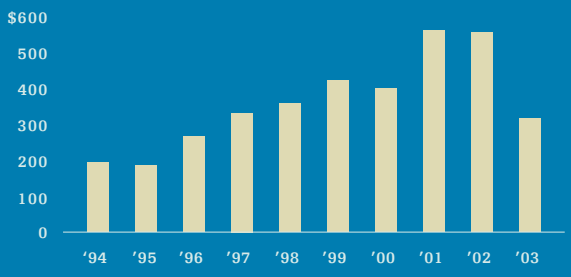


Cumulative

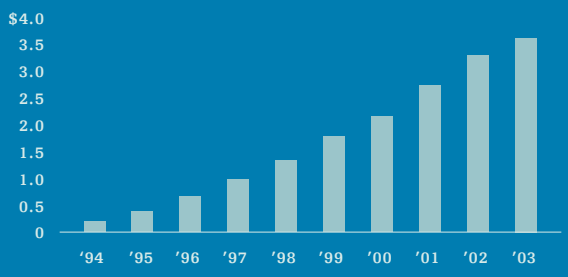


DOLLAR AMOUNT OF GRANTS AND CONTRACTS AWARDED 1994–2003

Individual Years (in millions)

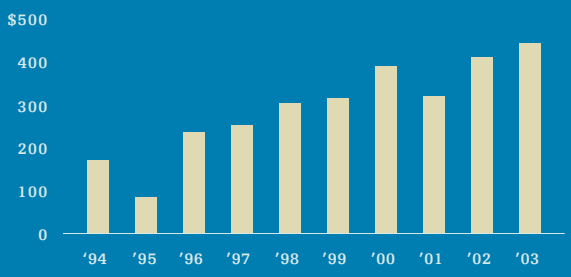


Cumulative (in billions)

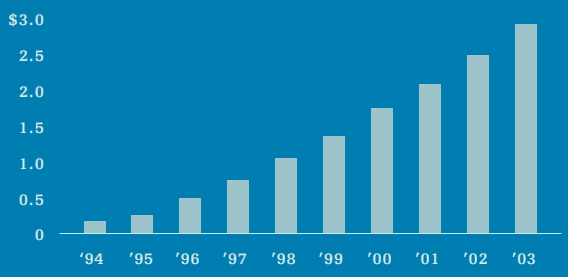


DOLLAR AMOUNT OF GRANTS AND CONTRACTS PAID 1994–2003

Individual Years (in millions)



Cumulative (in billions)



** "Grants and Contracts Awarded" reflects program commitments made in the current year (2003) for program activities, for which payments may be made in 2003 or in subsequent years.*

*** "Grants and Contracts Paid" reflects program authorizations and awards made in the current year (2003) or in prior years for which payments were made in 2003.*

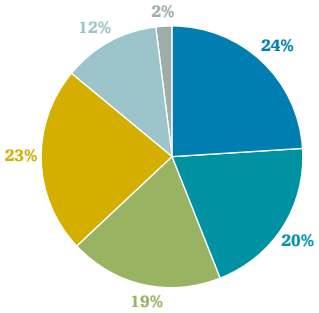
Distribution of 2003 Funds

During 2003, the Foundation made 927 grants and contracts, totaling $316.5 million in support of programs and projects to improve health and health care in the United States. These awards, viewed in terms of the Foundation's principal objectives, were distributed as follows.

DISTRIBUTION OF AWARDS BY GEOGRAPHIC REGION ($316.5 million)

REGION	PERCENTAGE OF RWJF FUNDS	REGION	PERCENTAGE OF RWJF FUNDS
West-North-Central	4.24%	East-South-Central	2.92%
East-North-Central	11.76%	West-South-Central	2.03%
New England	10.32%	Mountain	3.62%
Middle Atlantic	24.04%	Pacific	19.75%
South Atlantic	21.32%		

DISTRIBUTION OF AWARDS BY GOAL ($316.5 million)



24% **Access** $76.53 million for programs that assure that all Americans have access to quality health care at reasonable cost.

20% **Chronic Health Conditions** $63.33 million for programs that improve the quality of care and support for people with chronic health conditions.

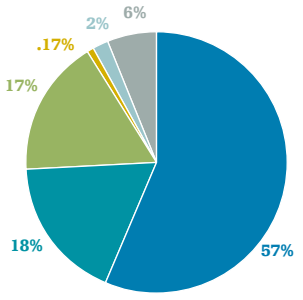
19% **Health & Well-Being** $61.27 million for programs that promote healthy communities and lifestyles.

23% **Substance Abuse** $71.39 million for programs that reduce the personal, social and economic harm caused by substance abuse—tobacco, alcohol and illicit drugs.

12% **Other Health and Health Care** $37.05 million for other health and health care programs.

2% **General Philanthropy** $6.93 million for projects addressing the Foundation's mission mainly in New Brunswick, New Jersey where the Foundation originated.

DISTRIBUTION OF AWARDS BY PORTFOLIO AND OBJECTIVE ($316.5 million)



57% **Targeted** $181.26 million for programs that achieve specific improvements in targeted health and health care fields within a defined time frame.

18% **Human Capital** $55.79 million for programs that center on attracting, developing and retaining high-quality leadership and a workforce to improve health and health care.

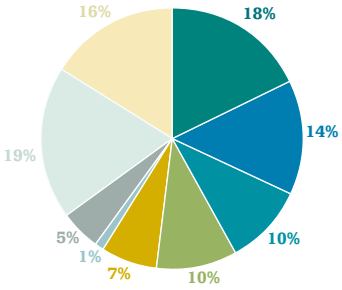
17% **Vulnerable Populations** $55.06 million for programs that center on supporting and disseminating innovative community programs that improve and sustain health and health care outcomes for vulnerable populations.

.17% **Pioneer** $527.5 thousand for programs that seek and support innovative undertakings that could lead to breakthroughs in health and health care.

2% **New Jersey** $5.52 million mainly for programs in New Brunswick and the surrounding Middlesex county communities.

6% **Other** $18.34 million for programs that are consistent with the Foundation's overall mission but are not aligned with a portfolio or targeted objective.

DISTRIBUTION OF AWARDS WITHIN THE TARGETED PORTFOLIO, BY OBJECTIVE ($181.26 million)



18% **Addiction Prevention and Treatment** $33.40 million

14% **Childhood Obesity** $26.22 million

10% **Coverage** $18.65 million

10% **Disparities** $17.38 million

7% **End-of-Life Care** $12.70 million

1% **Nursing** $2.31 million

5% **Public Health Leadership and Capacity** $8.26 million

19% **Quality** $34.10 million

16% **Tobacco** $28.24 million

Financial Statements

The annual financial statements for the Foundation for 2003 appear on pages 65 through 72. A listing of awards in 2003 begins on page 27.

In 2003 the net assets of the Foundation increased 1.4 percent. Overall, our total fund return for the year was 6.48 percent (net). This performance was offset by the large amount of program payments to grantees and contractors in support of our mission. This past year was a high watermark in that regard, with program payments totaling $441 million or 5.85 percent of our average asset value. When coupled with our program development, general administration and evaluation expenses ($46.3 million), the Foundation spent 6.46 percent of its average asset value, substantially exceeding the 5 percent payout requirement mandated by the tax law governing private foundations.

Concurrent with the increase in our program payments, we continued to focus inward on our internal expenditures. As a result, general administration expenses for the year were $20.8 million, a decrease of 9 percent compared to last year.

Investment expenses, comprised primarily of fees paid to outside investment managers, totaled $24.5 million, an increase of $319,000 compared to last year. Federal and state taxes amounted to $5.7 million.

The Internal Revenue Code requires private foundations to make qualifying distributions of 5 percent of the fair market value of assets not used in carrying out the charitable purpose of the Foundation. These distributions are to be completed within twelve months of year-end. The Foundation has fulfilled its 2002 requirement of $412 million. The 2003 requirement is approximately $378 million.

Peter Goodwin
Vice President and Treasurer

REPORT OF INDEPENDENT AUDITORS

To the Trustees of
The Robert Wood Johnson Foundation

In our opinion, the accompanying statements of financial position and the related statements of activities and cash flows present fairly, in all material respects, the financial position of The Robert Wood Johnson Foundation ("the Foundation") at December 31, 2003 and 2002, and the changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America. These financial statements are the responsibility of the Foundation's management; our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits of these statements in accordance with auditing standards generally accepted in the United States of America, which require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

PricewaterhouseCoopers LLP

New York, New York
February 13, 2004

STATEMENTS OF FINANCIAL POSITION

At December 31, 2003 and 2002 (in thousands)	2003	2002
Assets:		
Cash and cash equivalents	$ 190,837	$ 388,123
Receivable on pending securities transactions	32,875	52,613
Interest and dividends receivable	8,703	11,576
Contributions receivable	10,131	14,069
Investments at fair value:		
Johnson & Johnson common stock	4,158,589	4,664,886
Other equity investments	2,586,726	2,071,722
Fixed income investments	872,558	730,733
Program related investments	10,076	11,468
Other assets	63,266	67,177
Total assets	$7,933,761	$8,012,367
Liabilities and Net Assets		
Liabilities:		
Accounts payable and accrued expenses	$ 6,172	$ 6,502
Payable on pending securities transactions	86,750	160,006
Unpaid grants	571,784	671,874
Deferred federal excise tax	87,913	89,518
Accrued postretirement benefit obligation	9,899	12,331
Total liabilities	762,518	940,231
Net assets:		
Unrestricted	7,161,112	7,056,656
Temporarily restricted	10,131	15,480
Total net assets	7,171,243	7,072,136
Total liabilities and net assets	$7,933,761	$8,012,367

See notes to financial statements.

STATEMENTS OF ACTIVITIES

For the years ended December 31, 2003 and 2002 (in thousands)	2003	2002
Changes in unrestricted net assets		
Support and revenue:		
Investment income	$ 150,525	$ 143,151
Less: Federal and state tax	(1,288)	(1,186)
Investment expense	(24,503)	(24,184)
Contributions	11	—
Net assets released from restrictions	2,593	—
	127,338	117,781
Program costs and administrative expenses:		
Grants, net	285,107	443,000
Program contracts and related activities	55,399	56,044
Program development and evaluation	25,580	24,269
General administration	20,760	22,799
	386,846	546,112
Excess of program costs and expenses over income	(259,508)	(428,331)
Other changes to unrestricted net assets, net of related federal and state tax:		
Realized gains on sale of securities	446,758	284,683
Unrealized depreciation on investments	(82,794)	(942,281)
	363,964	(657,598)
Change in unrestricted net assets	104,456	(1,085,929)
Changes in temporarily restricted net assets		
Contributions	1,117	1,726
Change in value of charitable remainder trust	(3,873)	(610)
Net assets released from restrictions	(2,593)	—
Change in temporarily restricted net assets	(5,349)	1,116
Change in net assets	99,107	(1,084,813)
Net assets, beginning of year	7,072,136	8,156,949
Net assets, end of year	$7,171,243	$7,072,136

See notes to financial statements.

STATEMENTS OF CASH FLOWS

For the years ended December 31, 2003 and 2002 (in thousands)	2003	2002
Cash flows from operating activities:		
Change in net assets	$ 99,107	$(1,084,813)
Adjustments to reconcile change in net assets to net cash used in operating activities		
Depreciation	5,650	4,614
Net realized and unrealized (gains) losses on investments	(363,964)	657,598
Change in assets and liabilities		
Decrease in interest and dividends receivable	2,873	1,782
Decrease in contributions receivable	3,938	295
Decrease in program related investments	1,392	1,392
Decrease in accounts payable and accrued expenses	(330)	(2,218)
(Decrease) increase in unpaid grants	(100,090)	91,343
(Decrease) increase in accrued postretirement benefit obligation	(2,432)	2,281
Decrease (increase) in other assets	979	(1,512)
Net cash used in operating activities	(352,877)	(329,238)
Cash flows from investing activities:		
Proceeds from sales of investments	3,498,223	3,533,519
Cost of investments purchased	(3,339,914)	(3,169,481)
Acquisition of property and equipment	(2,718)	(6,090)
Net cash provided by investing activities	155,591	357,948
Net (decrease) increase in cash and cash equivalents	(197,286)	28,710
Cash and cash equivalents at beginning of year	388,123	359,413
Cash and cash equivalents at end of year	$ 190,837	$ 388,123
Supplemental data:		
Federal and state taxes paid	$ 5,745	$ 5,056

See notes to financial statements.

NOTES TO FINANCIAL STATEMENTS

1. Organization:

The Foundation is an organization exempt from Federal income taxation under Section 501(c)(3) and is a private foundation as described in Section 509(a) of the Internal Revenue Code.

The Foundation's mission is to improve the health and health care of all Americans. The Foundation concentrates its grantmaking in four goal areas:

- to assure that all Americans have access to quality health care at reasonable cost;
- to improve the quality of care and support for people with chronic health conditions;
- to promote healthy communities and lifestyles; and
- to reduce the personal, social and economic harm caused by substance abuse—tobacco, alcohol and illicit drugs.

2. Summary of Significant Accounting Policies:

The accompanying financial statements are prepared on the accrual basis, which is in conformity with accounting principles generally accepted in the United States of America.

Cash and cash equivalents represent cash and short term investments purchased with an original maturity of three months or less. The carrying value approximates fair value.

Marketable securities are reported on the basis of quoted market value as reported on the last business day of the year on securities exchanges throughout the world. Realized gains and losses on investments in securities are calculated based on the first-in, first-out method.

Investments in limited partnership interests are stated at fair value based on financial statements and other information received from the partnerships. Fair value is the estimated net realizable value of holdings priced at quoted market value (where market quotations are available), historical cost or other estimates including appraisals. Because of the uncertainty of valuations for certain of the underlying investments which do not have quoted market values, the values for those investments could differ had a ready market existed. The realization of the Foundation's investment in these partnership interests is dependent upon the general partners' distributions during the life of each partnership.

Property and equipment are capitalized and carried at cost. Maintenance and repairs are charged to expense as incurred. Depreciation of $5,650,312 in 2003 and $4,613,564 in 2002 was calculated using the straight-line method over the estimated useful lives of the depreciable assets.

The Internal Revenue Service provides that each year the Foundation must distribute within 12 months of the end of such year, approximately 5 percent of the average fair value of its assets not used in carrying out the charitable purpose of the Foundation. The distribution requirement for 2002 has been met and the 2003 requirement is expected to be met during 2004.

Deferred federal excise taxes are the result of unrealized appreciation on investments being reported for financial statement purposes in different periods than for tax purposes.

Net Assets Accounting—The Foundation reports information regarding its financial position and activities according to the following two classes of net assets:

- Unrestricted net assets are not subject to donor-imposed stipulations or the restrictions have expired.
- Temporarily restricted net assets are subject to donor-imposed stipulations that can be fulfilled by actions of the Foundation or that expire by the passage of time. Temporarily restricted net assets include $9,880,780 and $13,754,429 at December 31, 2003 and 2002, respectively, related to a charitable remainder trust and $250,000 and $1,726,000 at December 31, 2003 and 2002, respectively, related to a special program.

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues and expenses during the reporting period. The Foundation makes significant estimates regarding the value of limited partnership investments, discounts for contributions receivable and unpaid grants, and useful lives of property and equipment. Actual results could differ from these estimates.

3. Federal Taxes:

The Internal Revenue Code imposes an excise tax on private foundations equal to 2 percent of net investment income (principally interest, dividends, and net realized capital gains, less expenses incurred in the production of investment income). This tax is reduced to 1 percent for foundations that meet certain distribution requirements. In 2003 and 2002, the Foundation satisfied these requirements and is, therefore, eligible for the reduced rate.

In 2003 and 2002, the Foundation was liable for federal and state unrelated business income tax in connection with its limited partnership interests. The Foundation had no net liability for 2003. The amount paid in 2002 was $1,855,593.

The provision for federal excise tax consists of a current provision on realized net investment income and a deferred provision on net unrealized appreciation of investments. The current provision for 2003 on net investment income at 1 percent was $5,758,728. The current provision for 2002 at 1 percent was $4,037,118. The change in unrealized appreciation reflected on the statements of activities includes a provision for deferred taxes based on net unrealized appreciation of investments at 2 percent. The decrease in unrealized appreciation in 2003 and in 2002 resulted in a change of the deferred federal excise tax liability of ($1,605,379) and ($19,156,391), respectively.

4. Contributions Receivable:

Contributions receivable at December 31, 2003 and 2002 include $9,880,780 and $13,754,429 respectively, representing the present value of the estimated future benefit to be received as a beneficiary in a charitable remainder trust. The interest rates used to discount the trust receivable to present value range from 5.0 percent to 6.5 percent at December 31, 2003 and 6.0 percent to 6.5 percent at December 31, 2002.

5. Investments:

At December 31, 2003 and 2002, the cost and fair values of the investments are summarized as follows (in thousands):

	2003		2002	
	Cost	Fair Value	Cost	Fair Value
Johnson & Johnson Common Stock 80,499,208 and 86,853,208 shares in 2003 and 2002, respectively	$ 48,076	$4,158,589	$ 51,871	$4,664,886
Other equity investments				
Domestic equities	498,002	683,544	486,918	497,692
International equities	371,715	468,594	385,348	339,801
Alternative investments-limited partnerships	1,403,899	1,434,588	1,295,796	1,234,229
Fixed income investments	849,200	872,558	714,697	730,733
	$3,170,892	$7,617,873	$2,934,630	$7,467,341

Included in Domestic equities and International equities at December 31, 2003 and 2002 are approximately $165 million and $8 million, respectively, of securities on loan pursuant to a securities lending agreement.

Pursuant to its limited partnership agreements, as of December 31, 2003 and 2002, the Foundation had commitments of approximately $801 million and $748 million, respectively, which are expected to be funded over the next three to five years.

The Foundation purchases and sells forward foreign currency contracts whereby the Foundation agrees to exchange one currency for another on an agreed-upon date at an agreed-upon exchange rate to minimize the exposure of certain of its investments to adverse fluctuations in currency markets. At December 31, 2003 and 2002, the Foundation had open forward foreign currency contracts with notional amounts totaling $8.6 million and $40.5 million, respectively. Included in the statement of financial position at fair value are pending receivables of $8,853,246 and pending payables of $8,992,275, resulting in an unrealized loss of $139,029 at December 31, 2003 and pending receivables of $41,175,899 and pending payables of $41,740,617, resulting in an unrealized loss of $564,718 at December 31, 2002. Such contracts involve, to varying degrees, the possible inability of counterparties to meet the terms of their contracts. Changes in the value of forward foreign currency contracts are recognized as unrealized gain or losses until such contracts are closed.

The net realized gains on sales of securities for 2003 and 2002 were as follows (in thousands):

	2003	2002
Johnson & Johnson Common Stock	$338,385	$331,148
Other securities, net	112,830	(41,696)
Less, Federal and state tax	(4,457)	(4,769)
	$446,758	$284,683

6. Property and Equipment:

At December 31, 2003 and 2002, property and equipment, a component of other assets, consisted of (in thousands):

	2003	2002	Depreciable Life in Yrs.
Land and land improvements	$ 2,761	$ 2,677	15
Buildings	49,866	49,810	40
Furniture and equipment	17,519	14,941	3–5
Total	70,146	67,428	
Less, Accumulated depreciation	(12,324)	(6,674)	
Property and equipment, net	$57,822	$60,754	

7. Unpaid Grants:

At December 31, 2003 the unpaid grant liability is expected to be paid in future years as follows (in thousands):

2004	$305,919
2005	158,563
2006	94,265
2007	47,532
2008 and thereafter	17,659
	623,938
Less, discounted to present value	(52,154)
	$571,784

Generally accepted accounting principles require contributions made ("unpaid grants") to be recorded at the present value of estimated future cash flows. As of December 31, 2003, the Foundation has discounted the amount of unpaid grant liability by applying interest rate factors ranging from 5.0 percent to 6.5 percent and an estimated cancellation rate of 3 percent. At December 31, 2002, the unpaid grant liability was discounted to present value by $65,763,612.

8. Benefit Plans:

Retirement Plans

Substantially all employees of the Foundation are covered by two defined contribution retirement plans which provide for retirement benefits through a combination of the purchase of individually-owned annuities and cash payout. The Foundation's policy is to fund costs incurred. Pension expense amounted to $3,027,579 and $2,897,943 for 2003 and 2002, respectively, under these plans.

Postretirement Benefits

The Foundation provides postretirement medical and dental benefits to all employees who meet eligibility requirements. In addition, the Foundation had adopted supplemental benefit plans to provide additional benefits for certain key employees who met certain requirements. As of December 31, 2003, all amounts have been paid out on these supplemental benefit plans. The benefit obligation for 2003 and 2002 is summarized as follows (in thousands):

	2003	2002
Benefit obligation at December 31	$ 13,659	$ 14,762
Fair value of plan assets at December 31	—	—
Funded status	$(13,659)	$(14,762)
(Accrued) benefit cost recognized in the statement of financial position	$ (9,899)	$(12,331)
Weighted-average assumptions as of December 31		
Discount rate:		
Medical and dental plans	6.00%	6.50%
Supplemental benefit plans	—%	5.00%
Expected return on plan assets	N/A	N/A

For measurement purposes, a 9.0 percent annual rate of increase in per capita cost of covered health care benefits was assumed for 2004. The rate was assumed to decrease gradually to 5.0 percent for 2010 and remain at that level thereafter. Benefit information for 2003 and 2002 is summarized as follows (in thousands):

	2003	2002
Benefit cost	$1,849	$2,635
Employer contributions	441	354
Plan participants' contributions	2	—
Benefits paid	443	354

Secretary's Report

In January 2004, Linda Griego, trustee of the Foundation, was elected to the office of trustee emeritus. Griego served as trustee since January 1995 and was cited by the Board for her many years of loyal and distinguished service to the Foundation.

STAFF CHANGES

In April 2003, John R. Lumpkin, M.D., M.P.H., joined the Foundation as senior vice president and director of the Health Care Group. Prior to joining the Foundation, Lumpkin was director of the Illinois Department of Public Health. Lumpkin received an M.D. degree from Northwestern University Medical School and an M.P.H. from the University of Illinois School of Public Health. Lumpkin served an internship and residency at the University of Chicago Hospitals and Clinics.

In September 2003, Jan K. Malcolm joined the Foundation as senior program officer, focusing on public health. Prior to joining the Foundation, Malcolm served as commissioner of health for the state of Minnesota. Malcolm received a B.A. in philosophy and psychology at Dartmouth College.

Since the date of the last Annual Report, Calvin Bland has assumed the role of chief of staff and special advisor to the president and CEO; Peter Goodwin has accepted the new position of vice president for National Program Affairs; James C. Ingram, J.D., has assumed the role of Interim Co-General Counsel and Secretary; Carol G. Kroch, J.D., has assumed the role of Interim Co-General Counsel and Secretary; Kristine Nasto has assumed the role of operations manager, Foundation Services; and David L. Waldman has assumed the role of vice president, Human Resources and Administration.

Those departing the Foundation since the last Annual Report were the following: Jack Baron, operations manager, Foundation Services; Barbara Matacera-Barr, program officer; John D. Gilliam, chief investment officer; Terrance Keenan, special program consultant; Lewis G. Sandy, M.D., executive vice president; Mary Ann Scheirer, Ph.D., senior program officer; and J. Warren Wood, III, vice president, general counsel and secretary.

BOARD ACTIVITIES

The Board of Trustees met five times in 2003 to conduct business, review proposals, and appropriate funds. In addition, the Nominating, Human Resources, Audit, and Finance committees, and the Investment Subcommittee of the Finance Committee met as required to consider and prepare recommendations to the Board.

James C. Ingram, J.D.
Interim Co-General Counsel and Secretary

This report covers the period through January 31, 2004.

This document, as well as many other
Foundation publications and resources,
is available on the Foundation's Web site:

www.rwjf.org

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Route 1 and College Road East
Post Office Box 2316
Princeton, NJ 08543-2316