The
Robert Wood Johnson
Foundation
Annual Report 1978
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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*Coordinator, Clinical Scholars Program*
The president’s statement
Seven years have hurried by since The Robert Wood Johnson Foundation moved onto the national scene as a philanthropy devoting its resources to improving the health and medical care of Americans. Our annual reports since 1972 chronicle our evolution. During this period we have made almost 1,100 awards totalling $318.5 million. Many dedicated people using our funds are hard at work bringing their talents to bear on the problems which impede the appropriate distribution of modern medical and dental care to all who need it—particularly those not requiring hospitalization. There are many exciting new things happening in the organization and delivery of health care in the United States.

As also indicated in those same annual reports, early on we decided to underwrite objective external evaluations of our major programs to get a better understanding of how well they met their particular objectives. We are now in a position to report on the first four of these evaluations to reach completion. This report describes some of the highlights of those studies, which have closely examined one small segment of our total program.

Our decision to put substantial amounts of money and effort into objective external critiques of our programs was based on a number of considerations. Of primary importance was the belief that before new solutions would be absorbed into the mainstream of American life, a better educated and more sophisticated public would ask for objective evidence that demonstrations launched under Foundation funding were actually helping to reduce the problems at which they were directed. "What difference does it make in the lives of people?" is the tough question asked increasingly by elected officials, those working on national policy, and the public in general. Secondly, it was our belief that impartial, factual data about the effectiveness of particular programs would help answer a criticism regarding foundations as expressed in the Peterson Report of 1970:*

"Foundations apparently find the process of conceiving or making grants more satisfying and more worthy of their time and resources than evaluating success or failure of these grants, what was learned by them, and the extent to which the results were disseminated to an interested public."

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Last and most obvious, having made the decision to be mission oriented rather than a general purpose foundation, our trustees and staff needed solid, objective information on the programs supported to determine the extent to which they met our hopes.

Since 1972 we have provided $10 million for evaluations of 15 major programs which in the aggregate amount to Foundation grants of more than $150 million. As a general ground rule, if the Foundation invests more than a million dollars in a particular program that is to be conducted at multiple sites, or by multiple groups, a simultaneous evaluation is developed and undertaken. These studies are being conducted by skilled professional groups not themselves responsible for developing or running the programs.

Four major programs launched in 1972 and 1973 have now been concluded. The full evaluation reports and subsequent papers and monographs by those conducting these studies are, or will soon be, available for those who wish to examine the findings in depth.* For now, rather than attempting a true summary of these studies, I would like to share with you the findings which caught my eye and which seem to me the most important on which to base further efforts.

As will be apparent, evaluation of complex programs involving many institutions and many people cannot yet be classified as a precise science. While we are gaining in sophistication in this field, we fully recognize there is no well-tested prescription for how these important assessments of performance should be designed or carried out, but we are attempting to make them more precise and crisp each time.

Here, then, are some of the findings, both positive and negative, which stem from careful examination of these particular Foundation efforts. We still have much to learn, but this is our first harvest. There will be more.

A nationwide program of financial aid for students enrolled in medicine and osteopathy

In 1972 The Robert Wood Johnson Foundation awarded $10 million in grants to increase the amount of student aid monies available to young men and women entering schools of medicine and osteopathy. There was, at that time, federal legislation in place which put enormous pressures on medical schools to increase their output of physicians. However, the data then available suggested that the delivery of health services and the distribution of physicians by specialty or geographic location were not likely to be significantly affected by this increase in numbers unless serious attention was given to the selection of more students who might choose generalist careers or practice in medically underserved areas. After considerable study, we made our scholarship

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*For further information, write: Communications Office; The Robert Wood Johnson Foundation; P.O. Box 2316; Princeton, New Jersey 08540.
and loan funds available to students needing financial aid who came from minority backgrounds, to women students, and students from rural areas. The evidence then available suggested that these students tended to choose branches of medicine and practice locations which made it more likely that they would care for people most poorly served in urban and rural areas. Further, there were indications that a change in federal student aid policy was imminent—away from needy students to a much smaller number who would agree to serve tours in doctor-short areas following their training. Consequently, medical educators told us that the amount of student aid funds then available would be insufficient to maintain economically marginal students in school.

The evaluation was done by the National Planning Association (NPA) in Washington, D.C., which was asked to conduct a study to answer two deceptively simple questions. First, had we selected students who tended to choose generalist careers and subsequent practice in underserved areas? Second, were our funds needed? That is, were they of critical importance in placing young people from these backgrounds in medical or osteopathic schools and keeping them there?

Some of the answers were unexpected. Regarding the question, "Did we pick the right students?" the answers were mixed. Clearly the decision to support students from minority backgrounds seems to be leading to the anticipated results. Whether support awarded women students and students from rural backgrounds accomplishes a similar purpose is less clear.

In making their awards, institutions allocated over 50 percent of our funds to enroll and maintain minority students—predominantly black students—in medical school. Consequently the following findings seem of particular interest.

As shown in Figure 1, the race of office-based practicing physicians is an important determinant of the race of patients that they serve in ambulatory practices. Because medicine is a culturally sensitive area of human interaction, different ethnic groups have always tended

<table>
<thead>
<tr>
<th>Figure 1</th>
<th>Race of Practicing Physicians as a Determinant of the Race of their Patients</th>
<th>Source: USPHS, National Ambulatory Medical Care Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Black physicians</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>black patients</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>white patients</td>
<td>10.5%</td>
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</tr>
<tr>
<td>other patients</td>
<td>2.5%</td>
<td></td>
</tr>
<tr>
<td><strong>White physicians</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>black patients</td>
<td>7.4%</td>
<td></td>
</tr>
<tr>
<td>white patients</td>
<td>90.4%</td>
<td></td>
</tr>
<tr>
<td>other patients</td>
<td>2.1%</td>
<td></td>
</tr>
</tbody>
</table>
to seek out physicians from their own culture. But until I saw the results of this study, I was unaware of the degree to which this also occurs along racial lines.

At this point in our history, black doctors serve almost exclusively black patients. However one may feel about this characteristic of current society, it must be kept in mind in planning for medical services. If medical care is to be equitably accessible to all, enlarging the number of black physicians is clearly of critical importance to the welfare of the nation.

The study also showed that black physicians were 26 percent more likely to choose a primary care specialty—family practice, internal medicine, pediatrics—than were young white physicians. Based on knowledge from earlier studies indicating that physicians tend to practice in the same geographic areas where they complete their postgraduate training, Figures 2 and 3 offer some evidence that black physicians are settling in the South, which is a relatively underserved region medically, and are also more likely to locate in large cities where low income minority people are heavily concentrated. Thus an increased supply of black physicians can be viewed as helping to improve the geographic distribution of physicians.

The data on women are less dramatic. Women choose primary care specialties in only slightly greater numbers than physicians in general. While considerably more go into pediatrics—14.5 percent of women in contrast to 5.5 percent of all physicians—fewer go into family or general practice. There is evidence, however, that women do tend to pursue somewhat different careers than their male counterparts. More women physicians are hospital-based and more are salaried—(17 percent versus 8 percent) and a greater proportion of these are in primary care specialties. This suggests that they work in large hospitals.

<table>
<thead>
<tr>
<th>Figure 2</th>
<th>Change in Black Physicians Training in the South Compared to Black Population in the South</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black interns and residents training in the South</td>
<td>1968</td>
</tr>
<tr>
<td>Black population residing in the South</td>
<td>1968</td>
</tr>
<tr>
<td>1974</td>
<td>53%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Figure 3</th>
<th>Recent Medical School Graduates Practicing in Central City Locations, 1975</th>
</tr>
</thead>
<tbody>
<tr>
<td>All U.S. graduates</td>
<td>0</td>
</tr>
<tr>
<td>Howard and Meharry graduates</td>
<td>64%</td>
</tr>
</tbody>
</table>
which tend to be located in underserved areas where they deliver more general medical care to low-income patients.

The data on students from rural backgrounds are more impressive. The study indicates that over 30 percent of physicians coming from towns of less than 10,000 return to rural practice. This represents a career choice for rural America which is about three times higher than observed among choices of students originally from urban areas.

Regarding the question: "Were our funds needed?" the answer was both no and yes. As shown in Figure 4, popular perceptions to the contrary, there was actually a surplus of aid funds available to students during the first three years of our program. The full financial impact of changes in federal strategies regarding government support of students was not felt during this period. Thus the NPA study showed, in retrospect, that more funds were available than actually required to meet baseline student needs during the period 1972-1975.

However, this situation changed dramatically in 1975-1976. At that time, the federal sector substantially reduced student support on the basis of need and shifted its funds to the development of the National Health Service Corps. The resultant sharp reduction in numbers of students assisted led to a decided problem for students needing financial help. Thus in 1975, the Foundation's funds became critically important, particularly to low income and minority students. Projections shown in Figure 4 suggest the needs have grown even more serious in subsequent years.

Obviously, such aggregate data do not show the differing needs of different schools over time. Some which did not have a surplus of funds in the 1970's benefited enormously from our support, but it seems probable that during the first three years of the program, the target groups of students would have remained in professional schools without our assistance.

The NPA study included a careful analysis of the relative importance of several other factors in determining the enrollment in medical school for minority and women students. This analysis drew on the findings of student and financial aid officer polls, as well as the insights provided by sophisticated models of the enrollment process. For one thing, the study revealed that financial aid was of less importance than generally believed. For example, special recruitment programs, general social change, and the presence of minority faculty members within a medical school were shown to be more influential for black students than student aid funds in promoting their enrollment. For women as well, programs designed to encourage their entry into medical school coupled with the general change in social attitudes regarding the appropriateness of women engaging in professional careers were said to be of more importance than the availability of student aid.

The evaluators also examined whether the way our funds were awarded was the most efficient use of limited monies to assure student
recruitment and retention. Our program was permissive. Each school could determine both who would receive student aid and how much of that aid would be an outright scholarship gift and how much would be awarded in loans. Here, the NPA study suggests that more of our funds were awarded in scholarships and less in loans than absolutely necessary. Studies of the income production of young physicians—those under 35—show that they move swiftly to incomes of $35,000 to $40,000 yearly after completing training. This represents an extraordinary “return” of 22 percent per annum on the costs of a medical school education—a splendid investment in anyone’s terms. Loan pay-backs should therefore present no insurmountable financial problem to most young physicians. Further study has shown that loans can provide almost 10 times more funds than can scholarships if appropriately deployed to the same end. On the basis of these data, in this period of grave shortages of dollars for social purposes, we have moved to a guaranteed student loan program to help offset the serious shortfalls in projected student aid for the years ahead.

In designing the 1972-76 program, we had a choice between giving support to the educational institutions themselves or funding a central agency to deal with individual students. We chose the former route. However, the evaluation suggests that making the awards to student-funding agencies like the National Fund for Medical Education or the United Student Aid Fund would probably have been more appropriate. Wealthier schools with more student aid monies tended to bid up awards to students within the special groups that were already in the pool. This had the unintended side effect of having certain schools with strong recruitment programs giving almost 25 percent more aid to those students than was perhaps necessary. Thus it would appear that

![Figure 4](Medical Student Aid Gaps and Surpluses Relative to Baseline Needs)

<table>
<thead>
<tr>
<th>millions of dollars</th>
<th>1972/73</th>
<th>73/74</th>
<th>74/75</th>
<th>75/76</th>
<th>76/77</th>
<th>77/78</th>
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<td>0</td>
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<tr>
<td>baseline needs</td>
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<td>5</td>
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<td>-15</td>
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</tbody>
</table>

- Women and minority students and students from rural backgrounds
- Minority students
student funding agencies would have been able to support larger numbers of needy students with the same philanthropic contribution.

In examining these findings, the dominating influence of federal funding decisions was brought forcefully home to us. In 10 years, federal policy regarding student aid has changed three times: from student aid based on ability, to student aid based on financial need, to the most recent decision of student aid based on subsequent service commitments. We have learned several things from this study.

First, because federal funds are such a large component of medical and osteopathic student aid, philanthropic groups must be very knowledgeable about, and up-to-date on, federal strategies, if they are to play an effective role.

Second, targeting on particular groups of students can only modestly—not dramatically—change the selection of career and practice location.

Third, external funds to support needy students in schools of medicine and osteopathy are now critically needed.

Last, funds made available through guaranteed loan programs seem to be the way of getting the greatest return for monies expended to keep economically deprived students in school, and providing such funds through a central agency dealing directly with students probably distributes philanthropic dollars most broadly and equitably.

A nationwide program to develop regional emergency medical communications systems

In focusing on barriers that Americans encountered in obtaining access to medical care, the difficulty many seemed to be having in getting immediate and appropriate help in emergency medical situations soon caught our attention. In 1973 the Foundation made almost $15 million in awards to 44 sites in 38 states to develop regional emergency medical communications networks. A number of studies had suggested that the technical knowledge required to develop coordinated systems was available, but communities were having trouble getting beyond a variety of jurisdictional and geographic problems.

The value of emergency medical care was not an issue for us. Our concern was getting appropriate emergency services to patients, or patients to the services, with greater speed and effectiveness. We hoped to demonstrate that regionalized programs with inter-jurisdictional coordination could accomplish this objective. The Foundation’s program was aimed at encouraging local communities to band together to establish well planned, regional emergency medical communication arrangements to coordinate services and dispatch ambulances throughout relatively large geographic areas or population centers.

Two quite different assessments of this program were conducted. A committee of the National Academy of Sciences composed of experts in all facets of planning and operating emergency medical service
systems, which advised us on the programs, did on-site reviews of all 44 regions. An independent study, conducted by the Rand Corporation, was planned and funded shortly after the start of the program. The Rand study of a sample of preselected sites was designed to assess the effect of full regionalization of emergency services on access to services, on speed of treatment, transfer to appropriate hospitals, and communication between hospitals and personnel in emergency vehicles. We also hoped to get some information on the lifesaving capability of such programs, although this issue was not central to the study.

When planning the Rand Corporation study, the Foundation was early in its development, and our lack of experience in service programs and evaluation alike led us to make several fundamental errors. First, our goals for full regionalization were unrealistically high. Second, the time frame for the conduct of the study was wrong—we started too early and the two-year period of the evaluation was too short. Third, the appeal of the program seemed so great and its advantages so obvious to us, that we expected good data from all programs. Thus only seven of the 44 sites were selected for the Rand study. Although we had made participation in the evaluation a precondition of the grants, neither the grantees nor we were aware how difficult and time consuming it would be to gather data from the multiple groups and organizations comprising regional emergency medical service systems. This resulted in three of the seven sites having such incomplete data that they were excluded from the final analysis. In retrospect, we expected too much, we looked too soon, and the sites were too few in number to obtain solid answers to the questions of most compelling interest to us.

Within the preselected sites studied by Rand, regionalization as measured by any rigorous criterion such as cross-county ambulance runs, or assignment of hospital destination based on matching a patient’s problems with institutional capacity, simply did not occur during the period of the study. In the absence of full regionalization—perhaps an unrealistic goal—the Rand group was unable to determine whether such coordinated services could make the differences we had predicted would occur.

However, the Rand study did show that the Foundation funds had brought together the various aspects of emergency services operated under different geographic and institutional jurisdictions in new administrative arrangements. Four years later, the on-site reviews conducted by the National Academy of Sciences also indicated that by this time the majority of regions were effectively operating multi-jurisdictional programs.

The Rand study had some other interesting findings. First, it was clear in the seven regions studied that access to emergency care prior to launching the program was not as deficient as thought. Despite the complex nature of arrangements regarding notification of emergencies,
dispatch of ambulances and the like, people seemed to be getting to care more promptly than was commonly supposed. However, problems in tracking those who tried to get, but failed to receive, emergency care makes this observation less certain than one would wish, although from what we can ascertain this group is very small.

The most important finding of the Rand study with respect to planning future strategies was the critical importance of the kind and extent of medical training of those who staff ambulances. One of the hopes of the program was to improve direct communications between ambulance attendants and expert physicians in the hospital so that patients would be properly managed during the critical moments between the medical catastrophe and arrival at the hospital.

The Rand study clearly showed that it required the presence of highly trained paramedics, who can administer definitive care in the ambulance, for such communications to occur. There was far less communication with emergency medical technicians (EMT's), who receive less training and can stabilize patients but not give definitive care.

As an example, in San Bernardino County, California, where the implementation of ambulance-to-hospital communications was accompanied by training of large numbers of paramedics, physicians prescribed treatment for 65 percent of severe cases en route when a paramedic and an EMT were in the ambulance together, but in only seven percent of such cases when the lesser-trained EMT was aboard alone. These data are summarized in Figure 5. The Rand research suggests the development of paramedic-EMT teams as a possible next important step in improving emergency medical care.

The value of such communications—and notification of the hospital of the nature and the severity of the problem being brought to it—
was borne out in yet other ways by the Rand study. It was shown that
pre-notification increases the chances that the patient will be seen by a
physician, that the physician will be present in the emergency room
when the patient arrives, and sharply cuts the delay in treatment—
from 27.3 minutes to 10.7 minutes in the region examined.

The National Academy of Sciences observations showed that the
Foundation-supported programs trained large numbers of new
emergency medical personnel. These data are shown in Figure 6. The
Rand findings suggest that it may be wise to shift the emphasis of
future training to include larger numbers of paramedics.

As shown in Figure 7, the first step in regionalization—progress
toward centralization of responsibilities and agreement on a central
telephone number—was satisfactorily accomplished in most regions by
the end of four years. But while the number 911 provides the easiest
telephone access to emergency services, the Rand findings underscore
how difficult this changeover is to implement at the local level.

As noted in Figure 8, there were also marked improvements in the
communications linking ambulances to hospitals and the linking of
central medical emergency dispatchers with fire departments, police
departments, and other dispatchers in other regions. These seem clear evidence of improvement in multi-jurisdictional linkages.

Because of the design of the Rand study and the early recognition of the complexity of such an evaluation, we are unable to answer the question of greatest interest to all: do regionalized programs save more lives? Here we have only softer data, much of it anecdotal, supplied from the regions themselves. But such as it is, it seems to point in the right direction. Data from the city of Newark, New Jersey, comparing deaths in control areas in which the coordinated system was not in place with those in which it was, suggest that deaths from accidents and those produced by motor vehicles were significantly decreased. In Newark the program was able to drop the response time from notification to on-site management of emergencies by almost 50 percent. Bits and pieces of data from other areas—Florida, East Lansing, Peoria and other regions—also suggest greater lifesaving capacity when coordinated systems are in place, but the data lack rigor and control.

There are, however, some figures emerging that deserve mention. A series of papers from the Seattle project* demonstrates the value of paramedics in saving individuals who have undergone cardiac arrest—an all too common event synonymous with death in years past.

In a two-year period in the Seattle emergency medical service region, EMT's cared for 301 individuals with cardiac arrest. Six percent of these patients were subsequently discharged alive from the hospital. In contrast, of 569 receiving treatment from paramedics, 20 percent went home and have been similarly followed. Their composite studies indicate that an individual with cardiac arrest is 4.4 times more likely to survive if treated by a paramedic. The findings suggest that paramedic services have a small but measurable effect on the community's cardiac mortality rate: a drop of 1.3 percent if managed by EMT's; a drop of 8.4 percent if a paramedic is in attendance.

Review of these papers shows quite dramatically the "why" for this striking difference in outcome. The paramedic, unlike the EMT, is trained to give definitive care for cardiac arrest, and it is the time which elapses between the event and (a) cardiopulmonary resuscitation, plus (b) definitive treatment (restoring normal heart rhythm or re-starting the heart) that makes the critical difference.

As shown in Figure 9, if cardiopulmonary resuscitation (CPR) was started within four minutes, and definitive treatment given within eight minutes, 51 percent of these "dead" patients were subsequently


discharged alive from the hospital. If both time periods were exceeded, only five percent survived to return home.

These important studies suggest all kinds of new strategies for those concerned with emergency medical care. Training laymen to administer CPR was shown to have an important positive effect on outcome, and Seattle launched a large community program to do just this. Plans for recasting the training of emergency personnel to permit earlier treatment of the arrest is suggested in communities where these skills can be appropriately utilized. We need more such studies.

So these are the results of this program to date. Not as dramatic as we had hoped, but nevertheless encouraging. Obviously our program did not start from scratch. Most American communities have ways of delivering medical services in emergencies; hence problems of access were not as great as we had believed. The voluntary efforts of communities to develop these complex systems cannot be evaluated over a short time frame, and completely regionalized systems are harder to put together than we had originally thought. Getting communities to organize central dispatching services, to share ambulance services across city, county or other political boundaries, and the myriad of other details required are long-term propositions. But the federal sector has now launched a much larger effort, and we have been the catalyst for a program which looks promising.

Most encouraging, the National Academy of Sciences report suggests a continuing commitment to the program. Over 75 percent of the regions are now self-sustaining financially and have broad public acceptance and support.

**Strengthening the role of state legislatures in improving American health care**

In 1973 a number of federal mandates were placing sudden, massive, and different responsibilities for health legislation at the state level. Aggregate state spending for health had risen from $3.5 billion in 1965 to $15.9 billion in early 1974—largely for Medicaid programs—and accounted for the largest percentage increase in any state budgetary item during this decade. Where state legislatures had previously dealt largely with public health matters, in 1973 they were playing an increasingly key role in personal health and medical affairs.

<table>
<thead>
<tr>
<th>Table 9</th>
<th>Percent of People Discharged Alive From the Hospital Following a Sudden, Out-of-Hospital Cardiac Arrest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiopulmonary resuscitation</td>
<td></td>
</tr>
</tbody>
</table>
< 4 minutes | > 4 minutes | < 4 minutes | > 4 minutes |
| Definitive care | 
< 8 minutes | < 8 minutes | ≥ 8 minutes | ≥ 8 minutes |
| Survival to hospital discharge | 
51% | 25% | 15% | 5% |
The federal government, recognizing this growing and changing role of states in health was concentrating on developing new administrative structures, like planning agencies, to help states deal more effectively with health and medical issues.

On the other hand, the Citizens' Conference on State Legislatures (now named Legis 50) believed, and we agreed, that for legislators to deal intelligently with this avalanche of new responsibilities, the various committees of state legislatures dealing with specialized areas of knowledge required better staffing. It was our reasoning that with so many federal health programs being transferred to states, it would help to have competent professional staff working with policymakers to lay plans in health areas before, rather than after, public programs were implemented. This followed a trend: as shown in Figure 10, state legislatures were rapidly increasing the number of professional staff to help them make difficult and complex policy and priority decisions in all legislative areas.

In late 1973 and early 1974, the Foundation allocated $2 million to allow selected states to recruit and hire professionally qualified health experts to staff standing committees on health. Our 15-member advisory committee tried to pick states that varied widely in the staffing patterns of their legislatures, in geography, and political outlook.

Of the eight states initially awarded grants for two years, only four were able to genuinely implement the staffing, and their support was continued for an additional two years. A group at Georgetown University undertook to study both the funded states and a series of control states to determine the impact of the program. As it turns out, this study represents the largest ever undertaken about the effects of committee staffing on state legislative processes. The study made use of state data and the results of interviews with over 600 individuals, including state legislators, state government officials, personnel in various health agencies, lobbyists for groups concerned with health issues, members of the press, and many others.

Again, we were trying to answer some deceptively simple questions.

<table>
<thead>
<tr>
<th>Figure 10</th>
<th>Number of Professional Staff Working With State Legislatures in the United States</th>
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<tr>
<td><strong>Central legislative staffs</strong></td>
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<tr>
<td>1968</td>
<td>547</td>
</tr>
<tr>
<td>1974</td>
<td>753 + 38%</td>
</tr>
<tr>
<td><strong>Legislative budget agencies</strong></td>
<td></td>
</tr>
<tr>
<td>1968</td>
<td>114</td>
</tr>
<tr>
<td>1974</td>
<td>181 + 59%</td>
</tr>
<tr>
<td><strong>Legislative committees</strong></td>
<td></td>
</tr>
<tr>
<td>1968</td>
<td>65</td>
</tr>
<tr>
<td>1974</td>
<td>495 + 662%</td>
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First, did the presence of professional staff improve legislative performance in the health area? Second, was the decision-making of state legislators sounder, better informed and more independent? Third, did the public feel it had more input to the decision-making process about matters affecting health and medical care? Lastly, if the answers to the first two questions were yes, would other states adopt professional staffing for their health committees?

The evaluation suggests that the presence of qualified professional staff did, indeed, make a difference in overall health policy legislative performance. As shown in Figure 11, the number of legislators who rated their state legislatures’ ability to handle health issues as good or very good was significantly greater in the model staffing states than in states lacking such professional assistance. Also, as shown in Figure 12, the presence of specialized staff in health markedly increased the amount of health legislation and the allocation of resources to the health area, although whether this is a plus or a minus depends on one’s point of view. There was also considerable agreement that professional staff improved the capacity of the legislature for independent policy making. Ninety-three percent of state legislators in the funded states reported that the model staffing program had made them more knowledgeable about health issues, less reliant on information supplied by special interest groups, and more open to the concerns of individuals and groups who did not earn a living from working on health matters.

Clearly a professional staff increased the accessibility of the legislative process to consumers and other groups in ways that seemed both

<table>
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<tr>
<th>Figure 11</th>
<th>'Good' and 'Very Good' Ratings Given to Legislatures for Their Ability to Handle Health Issues</th>
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<tr>
<td></td>
<td>0</td>
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<tr>
<td>Legislators</td>
<td>control states</td>
</tr>
<tr>
<td></td>
<td>staffed states</td>
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<tr>
<td>Non-legislators</td>
<td>control states</td>
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<td>staffed states</td>
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<th>Figure 12</th>
<th>Changes in Legislative Health Activity During Staffing Program</th>
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<tbody>
<tr>
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<tr>
<td>Increase in number of health bills introduced in the legislature</td>
<td>control states</td>
</tr>
<tr>
<td></td>
<td>staffed states</td>
</tr>
<tr>
<td>Growth in health expenditures</td>
<td>control states</td>
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<td></td>
<td>staffed states</td>
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sound and democratic—over 60 percent of all respondents representing the public believed the programs had helped increase their access to the legislative process when compared with previous years. There was greater public input to the process brought about through greater numbers of scheduled public hearings, and greater availability of information on various bills. Even 82 percent of the press—a notably tough-minded and critical group—felt that the presence of specialized staff helped them improve their coverage of health issues. Since public confidence in being able to reach political institutions is a major tenet underlying our democracy, this finding seems gratifying.

It was also apparent that professional staff in the health area provided a different type of service to legislators than traditional generalist staffing. As noted in Figure 13, the single most important service appeared to be the provision of expert advice of an independent nature. Legislators were required to rely less on summaries of the advice of others, and this appeared to contribute to legislative independence. When asked during the final round of interviews if the quality of legislation had been improved, 87 percent of those in states receiving four-year support answered yes.

On the last question—namely, if the program appeared to be effective, would other states adopt it—the answers were mixed. None of the states supported continued it for their health committees or adopted this model of specialized committee staffing for other standing committees. Although all agreed that the program had been highly effective, it was not possible to continue staff in the health area without doing the same in others, and that was precluded by funding constraints. Be that as it may, the results suggest that providing specialized staff to state legislatures may be a powerful way of improving a state's capacity to deal with complex matters in the area of health. The program was of sufficient broad general interest that eleven other states adopted the committee-staffing concept, making use of federal and other foundations' monies to implement their new staffing programs, and the concept is of increasing interest in many states.

<table>
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<tr>
<th>Figure 13</th>
<th>The Single Most Important Service Provided by Staff: The Opinion of Legislators</th>
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<tbody>
<tr>
<td>Providing expert advice</td>
<td><strong>control states</strong></td>
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<tr>
<td>Summarizing the advice of others</td>
<td><strong>control states</strong></td>
</tr>
<tr>
<td>Other services</td>
<td><strong>control states</strong></td>
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In summary, the basic worth of offering hardworking state legislators professional assistance in an area as complex and controversial as health seemed confirmed—it worked very well. Other states paid close attention, a number adopted the concept, and it was generally agreed that legislation was improved. As with the emergency medical services program, it was clearly apparent that changes do not take place overnight, even when judged as highly effective, especially when they involve anything as fundamental as how states govern themselves. Nevertheless, it is an idea viewed very positively by state legislatures, and it is receiving continuing study.

**Primary care residency training programs in internal medicine and pediatrics**

As soon as agreement on the Foundation's principal objectives was reached in 1972, our attention was directed to how we might help slow or offset the dwindling supply of physicians delivering general out-of-hospital care—primary care, as we termed it. In the early 1930's, almost 70 percent of our physician population were generalists, but by 1972 this had dropped to 28 percent in a steady, continuing decline. Since 1973, in an effort to correct this trend, the Foundation has funded nine academically based primary care residency programs in internal medicine and pediatrics for a total outlay of $10.7 million.

Physicians considered to be most involved in delivering primary care include family practitioners, internists, pediatricians and sometimes obstetrician-gynecologists. All routes appear appropriate. However, as we began our efforts, the federal sector and a number of states had made the decision to encourage growth in family practice through heavy subsidies for residency training programs in that field. The number of such programs has rapidly and steadily expanded since that time. But it was our belief that simply going this one route might not correct the national imbalance in numbers between primary care and specialty physicians. We felt that even with this expansion in family practitioners, the need for primary care could not be met in the foreseeable future by this group of physicians alone. Further, faculty required for training family practitioners were not generally available in medical schools—and we are supporting efforts to remedy this—so internal medicine and pediatrics will continue to be major sources of physicians who give generalist care. Thus the Foundation's funds for primary care training of physicians have gone to help academic centers to develop generalist training and careers in internal medicine and pediatrics, as contrasted with the traditional emphasis in these specialties on subsequent subspecialty pursuits.

In conjunction with the federal sector, we have funded two studies. One, focusing on these nine residency programs, conducted at the University of California in San Francisco (UCSF). The other is being carried out at the University of Southern California (USC).
There were three principal questions toward which the studies were directed. First, did the internists and pediatricians trained for generalist roles compare favorably in their clinical skills with more traditional internal medicine and pediatric residents headed for subspecialty training and careers? Second, did the program run the hazard of developing a shallow physician who was less able to manage patients requiring more complex in-hospital care? Third, were primary care residency graduates more likely to provide generalist types of care in places where it was most needed?

Satisfactory answers to questions one and two have been obtained by the UCSF study. A major finding of this study, based on a careful review of the performance of 163 residents in training during the years 1976 and 1977, was that residents in internal medicine and pediatrics programs emphasizing primary care are judged every bit as good as those in traditional internal medicine or pediatric residencies as measured by their National Board scores, the assessment of their peers and teachers, and the quality of the medical schools in which they had received their undergraduate training. In sum, these young men and women could have competed successfully for any kind of residencies, but chose this new and broader career route.

The study shows that the mean scores for primary care residents on national exams administered by the National Board of Medical Examiners were the same or slightly higher in the areas of basic science knowledge, clinical science information, and clinical performance. A careful survey of judgments of medical school faculty, departmental chairmen, fellow residents, and other professionals with whom they worked—nurse practitioners and physicians' assistants—yielded confirmatory information. Seventy-seven percent of these respondents thought that the primary care residents had clinical skills equal to or better than traditional internal medicine residents. They were thought to be equally or more knowledgeable in the science of medicine by 71 percent, and even equally or more interested in clinical research by 50 percent. Perhaps more gratifying, 93 percent of the respondents believed that the young men and women who received special primary care training were equally or more socially oriented than their straight internal medicine counterparts.

The last and most important question—do physicians with such training practice differently or in different sites—cannot yet be answered. They are still making their career choices. It will, however, be addressed by the USC study, which is just beginning to bear fruit. This is a careful national examination of what physicians actually do in practice. The study is documenting the number and kinds of patients cared for by over 10,000 physicians in 24 specialties in their regular practice worlds. This study will, I believe, finally give all of us real data on which to make judgments about who actually delivers primary care services. An identical follow-up study will collect similar data on
graduates of our primary care residencies after at least three years in practice. Comparison of the practice patterns of this new group with the baseline information obtained from practicing physicians who received more traditional training should determine whether those trained for primary care do opt for different practice careers or merely bear a new label.

One finding in the completed UCSF study bears watching. About one-fourth of the primary care residents indicated that they planned a fourth year of residency training in a subspecialty area. Thus it is possible that these particular individuals may be lost to primary care practice. Our ongoing study should also answer this question.

Epilogue
These, then, are the fruits of our initial forays into evaluating programs. They have given us valuable insights and have, I believe, produced some unexpected information of value to health policymakers and others working to improve our American ways of delivering general medical care. We, at least, have certainly made use of the findings in shaping our more recent programs.

The reasons such evaluations are not often carried out are also increasingly evident to us. They require extraordinary care in their design and implementation if one is to answer genuinely significant questions. The tools used in assessment of complex programs involving many people and institutions are imperfect, data collection is enormously time consuming, such studies require continuing attention and patience to keep them on track, and their costs are at first—and sometimes in the end—startling.

The evaluations also vividly illustrate that one simply cannot assess the effectiveness of many major new ideas in less than five years—and probably many new ventures require more like a decade to determine their effect. There are few institutions today which can make such long-range commitments.

In some instances, our enthusiasm, impatience, and curiosity to know whether our programs have or have not been successful have led us to try to obtain data too early. Such impatience runs the hazard of a premature "evaluation" actually being harmful to the gestation of a new idea—witness the downbeat conclusions of the Rand study based on data collected only 18 months after the grants were made.

However, despite the difficulties, we remain convinced that in today's world, careful evaluation studies are increasingly important. The studies highlighted here have heightened our awareness that things are not always as they seem, and solid data, not anecdotes, are needed for proper decision making. They can, for example, show that individual assessments of the severity or magnitude of a problem may be grossly in error—witness the perceived desperate need for student aid funds in 1973 as viewed by the deans of individual medical schools.
Public policy decisions in health are increasingly difficult and expensive. Although there will never be enough information available, we must try to bridge the most important gaps in our knowledge. In addition, there are very different perceptions of the value of foundation activities or foundation-initiated programs by both the private and public sectors, and foundations need tough-minded and pragmatic documentation of the worth of their efforts carried out by trained, objective third parties. I wish we had equally rigorous evaluations of many public-sector programs.

At the time of this writing, we have three fundamental perceptions about foundation efforts directed at obtaining independent evaluations of the value of particular programs foundations assist.

First, we have partially satisfied ourselves that it is feasible for private foundations to use reasonably systematic and objective techniques to evaluate their work. While the tools are often primitive and the results less definitive than one would wish, they nevertheless do permit development of better guidelines and force more critical thinking about areas where conventional belief that one is doing "the Lord's work" can often lull one into avoiding objective assessments of performance.

Secondly, extraordinary patience and forbearance are required. Major new ideas or shifts in ways of doing things involving people and institutions take more time than logic or reason would indicate. One simply cannot expect to see shifts in arrangements which involve new groupings of people or practices at the same rapid rates than often follow the introduction of an impersonal new technology.

Lastly, we have come to the firm conclusion that foundations and others involved in major new programs designed to improve social ills or shortfalls should continue to try to determine the worth of their programs. Improvements in a society as complex as ours are never totally predictable or controllable, and that is not an altogether bad thing. Although painful to admit, conventional wisdom and obvious solutions, and the best of intentions, are sometimes wrong.

But despite the travails of unexpected or disappointing results, and the expense of such studies, there are too many demands for limited resources to permit entrenched opinions or anecdotal evidence to determine the allocation of these precious dollars. To learn by doing and by encouraging new kinds of solutions to old problems seems both right and appropriate—but the learning must be real so that subsequent decisions can be based on evidence made available for all to examine.

David E. Rogers
The 1978 grant program
The 1978 grant program

During 1978 the Foundation made 108 grants totalling $47.2 million. The types of activities supported and the allocation of funds to each were as follows:

- The development of improved ways to deliver ambulatory care services, $31.9 million, or 67.5 percent;
- The education and training of various types of health professionals needed to plan, staff, and manage ambulatory care services, $9.8 million, or 20.9 percent;
- The evaluation of major Foundation programs, $2.8 million, or 5.8 percent;
- The conduct of highly targeted health care research, and the development of other information intended to be useful to those formulating and evaluating public policy in health affairs, $2.7 million, or 5.8 percent.

Viewed in terms of the Foundation's objectives, the 1978 grant funds were apportioned as follows:

- $42.8 million, or 90.6 percent, for programs to increase access to primary care services;
- $1.9 million, or 4 percent, for programs to improve the performance of the health care system in order to ensure quality care;
- $1.4 million, or 3 percent, for programs to improve the formulation of public policy in health affairs;
- $1.1 million, or 2.4 percent, for charitable institutions and programs in the New Brunswick, New Jersey area where the Foundation maintains a historic and continuing interest.

Appropriations since the Foundation became a national philanthropy in December 1971 now total $318.5 million. A series of charts beginning on page 48 summarizes data from this seven-year period on proposals received, grants made, and a variety of analyses to portray how these funds have been allocated.

Program information
A description of selected 1978 grants concludes this section, but a list of all grants made in 1978 begins on page 71. This is followed by a list of grants made in previous years, and which were still active in 1978 (i.e., those with unpaid balances on January 1, 1978). A descriptive Program Summary for each of these grants is available free upon request. Requests should include the title of the grant, the institutional recipient, the grant ID number, and should be addressed to:

Communications Office  
The Robert Wood Johnson Foundation  
P.O. Box 2316  
Princeton, New Jersey 08540.

Also available without charge from the same address are copies of the following Special Reports:

- Regionalized Perinatal Services
- A New Survey on Access to Medical Care
- Emergency Medical Services
- New Roles for Nurses in Family Care; Citizen-Legislators: Coping with the Health Agenda: Unraveling the Battered Child Syndrome.
Major developments in the grant program

Evidence is accumulating that primary medical care is becoming accessible to more and more Americans. As a result, service programs and projects receiving Foundation assistance in 1978 were increasingly directed toward the remaining groups that continue to have problems getting care, especially residents of inner-city and rural areas, children of low-income families and the low-income elderly.

Municipal health services
Last year, 34 of the nation's 50 largest cities submitted detailed applications for five grants offered under the Foundation's Municipal Health Services Program, co-sponsored by the American Medical Association and the United States Conference of Mayors. This response seemed an accurate reflection of widespread concern and interest by local governments in improving primary care in inner cities. Each municipality pledged, if a grant was received, to draw upon resources of its city hospital and health department to offer primary care in at least three neighborhood locations. These medical service sites would offer underserved people an alternative to the city hospitals' outpatient clinics.

Upon recommendation of the Program's advisory committee, the Foundation made grants in 1978 to the municipal governments of Baltimore, Cincinnati, Milwaukee, San Jose, and St. Louis to implement their plans for offering care to a total of more than 650,000 people.

The federal Health Care Financing Administration has invited the selected cities to participate in a reimbursement study that includes special waivers of Medicaid and Medicare regulations to expand reimbursement for general and preventive services provided through the neighborhood sites.

A group at Columbia University, under a separate grant, is conducting an evaluation of the Program.

Other urban service programs
In addition to municipal hospitals and health departments, there are relatively few other established institutions—principally large hospitals and academic medical centers—which have indicated their commitment to staying in inner cities and continuing to offer primary care services. Four such institutions are the Drew Postgraduate School of Medicine in Los Angeles; Louisiana State University School of Medicine in New Orleans; Montefiore Hospital in New York; and the Sisters of Mercy Health Corporation operating three hospitals in Detroit.

Each is prepared to expand its primary care services to reach 35,000 to 60,000 people living in areas of severe medical need—census tracts where virtually all health and social indices are among the worst in the country.

In 1978 the first grants under the Foundation's Urban Health Initiatives Program were made to these four institutions to help them develop their plans. These grants are contingent upon the availability of federal funds and National Health Service Corps personnel to meet the operating needs of the expanded primary care efforts.

Primary care group practices
In Scranton, Pennsylvania, 27,000 people live in a medically under-served area of the city that is largely one of middle-income households, although unemployment is high and incomes in many of the households are below the poverty level. In addition, there is a large proportion of children and elderly people, and illness rates are high.

In response to these circumstances, and to meet medical needs in several adjacent
communities, a board of local residents and community leaders planned and in 1978 opened the Scranton Primary Health Care Center. The Center will be staffed by physicians, nurse practitioners, and a full-time administrator. In addition to a grant from the Foundation, the Center has received substantial assistance from local charitable sources, the national Campaign for Human Development, and the Kresge Foundation.

Four grants were also made in 1978 under the Foundation's Community Hospital Program to establish primary care group practices sponsored by participating hospitals in Michigan, Georgia, Kentucky, and the District of Columbia. A total of 50 community hospitals in 35 states are now developing practices under this program. Similarly, three small-town primary care group practices—in Michigan, North Carolina, and Virginia—received grants under the Foundation's Rural Practice Project during 1978, bringing the number of these practices to 13 in 12 states. Both of these Foundation programs are scheduled to conclude their grant-making in 1979.

School health services
A number of trends over the past few years have focused national and local attention on schools as logical sites for offering primary health care for children. However, a study funded by the Foundation in 1978 shows that many states’ laws and regulations for school health services now permit more extensive services than are generally being offered.

Based on several “model” projects, and months of planning that involved consultants from across the country, the Foundation's School Health Services Program was announced in 1977. Thirty states submitted applications for assistance, and in 1978, four grants were made under this program—to Colorado, New York, North Dakota and Utah. These states have now begun projects to employ nurse practitioners in selected schools where the children lack appropriate access to primary care services. Supervised by pediatricians in the participating communities, the school nurse practitioners will:

- Care for minor injuries, manage most common childhood illnesses, and identify potentially serious conditions requiring the attention of a physician or other health professional;
- Help children and their families locate needed medical services and then follow-up to make sure those services are received;
- Work with parents and physicians in the care of chronically ill and disabled children;
- Give immunizations, physical exams, and conduct periodic screenings for health problems.

Continuing a model project
A school-based health care project in Hartford, Connecticut, begun three years ago, is one of the models for the Foundation's School Health Services Program. Ninety percent of the 800 children in grades K through 6 in the demonstration school are Medicaid-eligible, and care is provided by two nurse practitioners and two aides, with physician backup. In addition, there is a part-time dentist overseeing a hygienist and aide.

The Foundation's 1978 grant will continue this project and support an evaluation that includes a comparison school.

Initial data indicate the nurse practitioners with physician back-up have been able to handle most of the health problems presented by the children. Moreover, children in the comparison schools have increased their use of hospital emergency rooms and outpatient services, but there has been a decline in the use of such services by children in the demonstration school.
Programs for the elderly
Three programs testing new approaches for meeting the special needs of elderly persons for a variety of health care services were started in 1978 with Foundation assistance.

The National Council on the Aging and a group of collaborating universities are establishing service and learning centers using students to provide a wide variety of services to older persons. These include medical, dental, and nursing care; speech and hearing therapy; and pharmacy and nutrition services.

Students will participate as part-time employees, as volunteers, or in field clerkships offering academic credit. The participating schools are Boston University, the University of Denver, George Washington University, the University of Georgia, Hampton Institute, and Indiana’s Consortium for Urban Education.

In Baltimore as in most communities, it is not unusual for indigent elderly patients to stay in the hospital longer than is medically necessary. They may have no one at home to care for them, and beds in nursing homes offering intermediate-level care are in short supply.

The Johns Hopkins Hospital is testing the feasibility of identifying and training surrogate families which, for a fee, will provide care in their homes to elderly patients discharged from the Hospital.

A physician-directed team of nurses and social workers from Johns Hopkins will serve as the patients’ primary and continuing source of health care and will monitor the surrogate families’ performances. A planned evaluation will seek answers to three questions:

- Is foster family care a cost-effective alternative to nursing home care?
- What improvements in the patients’ health and ability to function can be achieved by such care?
- What are the characteristics of families that provide effective care of patients in the home?
The United Way of the Minneapolis Area has convened a coalition of public and private agencies in a one-year planning effort addressing the problems experienced by the elderly requiring health and related services.

In this city, 20 percent of the population, or 87,000 people, are over 60 years of age. Over half of these people have incomes near or below the poverty level, and 20 percent live alone. Moreover, the provision of health and related services for the elderly follows a national pattern of responsibility fragmented among multiple institutions and agencies with substantial variations in eligibility requirements, service content and style, sites, and cost to the individual. The Minneapolis United Way coalition's ultimate objective is to overcome these barriers and develop a coordinated system of health and related services for the elderly.

Other service projects

Continued assistance was provided in 1978 for four service activities previously supported by the Foundation: a Vanderbilt University program to help rural communities develop and improve their health services; Georgetown University's prepaid Community Health Plan; the Barrio Comprehensive Child Health Care Center in San Antonio; and the University of Tennessee's involvement in a Memphis regional primary care network that was one of the models for the Foundation's Municipal Health Services Program.

Two programs announced

During 1978 planning was completed, advisory committees formed, and two new national programs were announced.

Under the Hospital-Sponsored Ambulatory Dental Services Program, hospitals with dental residency programs will be assisted to expand their outpatient activities to offer emergency, basic, and preventive dental care for people who currently lack adequate access to these services. Plans call for as many as 25 grants of up to $500,000 each during 1979.

The General Pediatrics Academic Development Program will assist six universities to train future faculty, to conduct clinical research, and to develop models of patient care—all centered on the medical problems commonly seen in the out-of-hospital practice of general pediatrics.

Applications for both programs have been received and reviewed, and most site visits were completed this year. Grants are expected to be made in early 1979.

Special assistance projects

The Rural Health Center Series—a six-volume set of handbooks prepared by a group of well-qualified authors for health professionals and community leaders alike—is scheduled for publication in the spring of 1979. The handbooks, prepared and published with Foundation support, are based on a study of 24 rural health centers staffed by nurse practitioners and physicians' assistants backed up by physicians.

The Series was prepared under the auspices of the University of North Carolina Health Services Research Center and the North Carolina Office of Rural Health Services. The six titles are: Rural Health Centers in the United States; Planning and Managing Rural Health Centers; Clinical Roles in Rural Health Centers; A Legal Guide for Rural Health Programs; Facility Planning, Design, and Construction for Rural Health Centers; and Medical Record and Index Systems for Community Practice.

A 1978 grant to Boston University will support a project offering developmental assistance for Individual Practice Associations (IPA's)—affiliations of independent physicians offering prepaid health care in accordance with provisions of the federal Health Maintenance Organization program. Operating out of the University's Health Policy Institute, the project will assist a
limited number of new IPA's with such tasks as attracting the initial complement of physicians, defining alternative benefit packages and master group contracts, and approaching insurance carriers to begin contract negotiations.

**Nurse practitioner faculty training**
Over the past seven years, the Foundation has supported nurse practitioner training to help expand access to primary health care services.

Two ingredients have made it possible for these new health practitioners to assume expanded clinical responsibilities. One is the medical skills they have acquired, such as history taking, physical examination, ordering and interpreting basic laboratory tests, and following diagnostic protocols and treatment plans. The other has been the development of systems of care in which nurse practitioners can use these and their nursing skills with appropriate physician supervision and collaboration.

To prepare nursing faculty for new careers as teacher-practitioners for the nurse practitioner profession, in 1978 the Foundation's Nurse Faculty Fellowship Program was extended two years beyond the initial three-year commitment. The new appropriations will enable a total of 100 faculty from throughout the country to complete one-year fellowships at the Program's four academic sites—the University of Colorado, Indiana University, the University of Maryland, and the University of Rochester.

Two other academic centers—the University of Washington and the University of Pennsylvania—also received grants in 1978 to implement their plans to become regional graduate centers for preparing nurse practitioner faculty.

**Emergency nurse/primary care training**
Last year the Foundation began a program to help a number of hospitals and schools of nursing develop primary care training for emergency department nurses from smaller, outlying hospitals in their regions. In 1977 two such programs were initiated. This year four additional institutions received grants to complete the series: Good Samaritan Hospital in Portland, Oregon; Hermann Hospital in Houston; Maricopa County General Hospital in Phoenix; and Nebraska Methodist Hospital in Omaha.

**Academic careers in family practice**
In 1977 the Foundation announced a Family Practice Faculty Fellowship Program with grants to four universities. In 1978, two additional universities became participants: Case Western Reserve University and the University of Missouri-Columbia. They will offer two-year fellowships to young physicians planning academic careers involving research, teaching, and the practice of family medicine.

**Training rural health aides in Alaska**
Since 1975 the Foundation has assisted the development of Alaska's program to train Rural Health Aides—Eskimos and Indians providing first-line medical care for 40,000 native peoples living in 200 villages scattered across the state's vast arctic and subarctic wilderness.

Progress to date includes the establishment of a coordinating office for the training program by the University of Alaska, publication of a manual for the aides, and the development of certificate and associate degree curricula for the aides.

A 1978 grant will support the development of course and teaching materials for implementation of the curricula and further strengthening of in-service training for existing aides and their assistants.

**Minority health career opportunities**
Four grants in 1978 continue the Foundation's support of selected institutions assisting
minority and other disadvantaged students interested in health careers:

1. Tulane University’s program for the recruitment and retention of minority students for medical school, including a summer enrichment experience, year-round counseling and tutoring, and help for other schools developing similar programs;

2. The National Fund for Medical Education’s program of small grants for medical school summer studies for minority premedical students;

3. The Association of University Programs in Health Administration’s recruitment of minority college students for graduate programs leading to careers in the management of health institutions; and

4. The University of Southern California School of Medicine’s programs of educational enrichment, counseling, and tutorials for disadvantaged premedical students within a consortium of six area undergraduate institutions.

**Guaranteed student loans**

With a previous year’s grant of $500,000, a total of $3.3 million was made available for borrowing by medical, osteopathic, and dental students under the Foundation’s Guaranteed Student Loan Program administered by United Student Aid Funds, Incorporated. In 1978, a $1 million grant for this program is expected to guarantee an additional $7 million in loans to supplement other assistance available for students in the three health professions.

**Perinatal program studies**

In 1975 the Foundation began a national perinatal program to establish eight regional systems to identify and care for the 15-25 percent of pregnant women at high risk to serious complications affecting their health or their babies’ health. The objective is to test the belief that the organization of such services on a regional basis would lead to a
reduction of maternal and infant deaths and birth defects.

In 1978 three grants were made for studies building further on this program. One grant to The Johns Hopkins University expands the scope and duration of the program’s principal evaluation, which also began in 1975.

Two other studies—at the University of Arizona and Case Western Reserve University—will use somewhat different approaches seeking to provide further clarification of the Program’s outcome by determining what proportion of high-risk infants admitted to the neonatal intensive care units (NICU’s) have survived and can be classified as “normal” three years later. Included in the Case Western Reserve University study is a comparison of outcomes between infants delivered in one hospital and then transported to the hospital with an NICU and those whose mothers were transported to the hospital with the NICU before giving birth. Both projects will periodically check the children’s physical, neurologic, and intellectual development and will help parents obtain any needed medical or social services.

Other program-related research
A group at the University of North Carolina has begun a national study of programs offering rural health care services. Various models have been identified—including the Foundation’s Rural Practice Project—for comparison with respect to their stability; cost; effects on access to care; and physician, patient, and local community satisfaction. The federal government and the Foundation are both participating in funding this project.

Another University of North Carolina group, also receiving both Foundation and federal support, has begun a study of the new and expanded role of state and local health departments developing ambulatory care services. This study will assess the potential of these agencies for designing and operating primary care services in underserved areas.

An inter-disciplinary group at Northwestern University will use a 1978 grant from the Foundation to study three areas of management related to ambulatory care services: (1) organizational arrangements that can reduce institutionalization of the elderly and chronically ill; (2) linkages with other health care services and providers that can increase the effectiveness of hospital emergency rooms, particularly for non-emergent problems; and (3) the use of mathematical modeling to develop optimal organization designs for ambulatory practices.

The town of Brookline, Massachusetts’ research and demonstration program to detect and prevent health and learning handicaps in preschool children also received continuing support. The educational and diagnostic service elements of this program will end at the conclusion of the 1978-79 school year, and work continues to refine and validate a number of new methods that have emerged from this program to detect problems and monitor child development.

Health policy fellowships
A 1978 grant to the National Academy of Sciences, Institute of Medicine will continue the Foundation’s Health Policy Fellowship Program until 1982. Under previous grants, thirty academic health center faculty members, by the end of 1979, will have completed one-year fellowships that include an intensive orientation to Washington health policy affairs and nine-month Congressional and/or executive branch staff assignments. The fellowships—six each year—serve the dual purpose of developing a cadre of academic health center faculty with firsthand knowledge of the federal health policy process, and providing federal policymakers with the assistance of competent professionals experienced in academic health affairs.
Each year the Foundation's grantees report the publications and other information materials that have been produced as a direct or indirect result of their grants. In 1978 these reports cited 64 books, 57 book chapters, 346 journal articles, 217 reports, and 63 films, tapes and other audiovisual materials.

This bibliography is a sample of citations from each category reported in 1978, and from among the publications of the Foundation's staff.

Books


Book chapters


Journal articles


Ullman, Ralph, James A. Block, Ned C. Boatright, and William C. Stratmann. "Impact of a Primary Care Group Practice on Emergency
Room Utilization at a Community Hospital.” *Medical Care*, 16(9):723-729, September, 1978.


**Reports**


Kohn, Margaret A., ed. *A State Survey of School Health Laws and Regulations and Health Service Requirements in Day Care Centers*


Scitovsky, Anne and Nelda N. Snyder. Medical Care Use by a Group of Fully Insured Aged; A Case Study. Hyattsville, Maryland: United States National Center for Health Services Research, 1975.


Audiovisual materials


Analysis of appropriations: 1972-1978
In 1972 The Robert Wood Johnson Foundation emerged as a national philanthropy with an overall goal to assist institutions and groups that are attempting to improve the American health care delivery system to make high-quality medical care more available for non-hospitalized Americans. Toward the achievement of this goal, three major objectives were defined:

- improving access to general health care services;
- improving the quality of health care, and the methods by which quality of care can be measured;
- improving the formulation and evaluation of public policy in health affairs.

In its first seven years as a national philanthropy, the Foundation made 1,093 grants, with appropriations totalling $318.5 million. The charts in this section show the use of these funds in relation to the Foundation's objectives, the proposals submitted to the Foundation, and the types of activities assisted in support of these objectives. The charts also depict the distribution of grants by geography and type of recipient, and the Foundation's grants in comparison with spending by other foundations and by the federal government.

All percentages and dollar amounts in the charts have been rounded.
Chart 1

Appropriations by RWJF Objectives, 1972-1978

RWJF 7-year appropriations: $318.5 million

Improving access to health care 76%

Improving the quality of health care 14%

Improving the public policy process in health 6%

Other 4%
Chart 2
Types of Activities Supported, 1972-1978

RWJF 7-year appropriations: $318.5 million

Education and training 35%
Expansion of health services 48%
Research and evaluation 14%
Other 3%
Chart 3
Types of Education and Training Programs Supported, 1972-1978

- 1% Fellows in health policy
- 1% Physicians and nurses for emergency services
- 1% Fellowships for family practice faculty
- 2% Managers for health services
- 2% Physicians’ assistants
- 2% Dentists to care for the handicapped
- 3% Primary care residents
- 4% Nurse practitioners and faculty training
- 4% Minority recruitment and retention
- 5% Clinical Scholars
- 6% Student aid for the health professions
- 4% Other

35%—$113 million

RWJF 7-year appropriations: $318.5 million
Chart 4

Types of Programs Supported to Deliver Health Services, 1972-1978

- 1% Health maintenance organizations
- 3% School health services
- 3% Preventive dental programs
- 5% Emergency medical service systems
- 5% Municipal health services
- 6% Regionalized high-risk pregnancy care
- 7% Community medical practices
- 11% Hospital-sponsored ambulatory care
- 7% Other

RWJF 7-year appropriations: $318.5 million

48%—$151 million
Chart 5

Types of Research and Evaluation Supported, 1972-1978

- 3% External evaluations of major programs
- 4% Health policy studies
- 7% Program-related studies

RWJF 7-year appropriations: $318.5 million

14%—$45 million
Comparison of 1972-1978 Requests Received* to Appropriations: by Foundation Objectives

*Includes only those proposals for activities relevant to the Foundation's objectives.
Comparison of 1972-1978
Requests Received* to Appropriations: by Types of Activities Funded

*Includes only those proposals for activities relevant to the Foundation's objectives.

- Health services expansion
- Education and training
- Research and evaluation
- Other

Proposals within Foundation's program:
$1.4 billion

Appropriations as proportion of requests:
$318.5 million
Chart 7

National Programs\(^*\) as a Proportion of Appropriations 1972-1978

\(\text{\textit{*Each of these programs comprises a series of grants assisting selected institutions or organizations addressing a specific, well-defined national problem within the scope of the Foundation's objectives.}}\)

<table>
<thead>
<tr>
<th>Percent of total appropriations</th>
<th>Dollars in millions</th>
<th>Percent of national programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>3%</td>
<td>$10.4</td>
<td>6%</td>
</tr>
<tr>
<td>48%</td>
<td>150.9</td>
<td>94%</td>
</tr>
</tbody>
</table>

51\%—$161 million

RWJF 7-year appropriations: $318.5 million
### Chart 8

**National Programs, 1972-1978**

<table>
<thead>
<tr>
<th>Program</th>
<th>Appropriations (millions of dollars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Hospital (group practice) Program</td>
<td>$28.7</td>
</tr>
<tr>
<td>Medical, Dental and Osteopathic Student Aid</td>
<td>20.9</td>
</tr>
<tr>
<td>Regionalized High-risk Perinatal Care Program</td>
<td>17.8</td>
</tr>
<tr>
<td>Clinical Scholar Program</td>
<td>17.0</td>
</tr>
<tr>
<td>Emergency Medical Service Systems</td>
<td>15.7</td>
</tr>
<tr>
<td>Municipal Health Services Program</td>
<td>15.2</td>
</tr>
<tr>
<td>Rural Practice Project</td>
<td>7.5</td>
</tr>
<tr>
<td>Preventive Dentistry Program</td>
<td>6.3</td>
</tr>
<tr>
<td>School Health Services Program</td>
<td>4.9</td>
</tr>
<tr>
<td>Dental Training for Care of the Handicapped</td>
<td>5.1</td>
</tr>
<tr>
<td>State Legislative Committee Staffing</td>
<td>3.2</td>
</tr>
<tr>
<td>Nurse Faculty Fellowships</td>
<td>3.2</td>
</tr>
<tr>
<td>Family Practice Faculty Fellowships</td>
<td>3.2</td>
</tr>
<tr>
<td>Health Policy Fellowships</td>
<td>2.3</td>
</tr>
<tr>
<td>General Pediatrics Academic Development</td>
<td>7.2</td>
</tr>
<tr>
<td>Hospital-Sponsored Ambulatory Dental Services</td>
<td>12.4</td>
</tr>
<tr>
<td>National program evaluations</td>
<td>10.4</td>
</tr>
</tbody>
</table>

The Robert Wood Johnson Foundation 57
Chart 9

Service Programs for Inner-city Minority and Rural Populations, 1972-1978

14% 9% 28% 27% 58% 64%
Black and Spanish speaking inner-city areas Rural areas All other areas

RWJF health service appropriations—$151 million
U.S. population—203 million people
Chart 10

1972-1978 Appropriations by Geographical Regions Compared to Population

Pacific: 14% RWJF Funds, 13% U.S. Population
Mountain: 7% RWJF Funds, 4% U.S. Population
West North Central: 6% RWJF Funds, 8% U.S. Population
East North Central: 13% RWJF Funds, 20% U.S. Population
Middle Atlantic: 22% RWJF Funds, 18% U.S. Population
New England: 8% RWJF Funds, 6% U.S. Population
West South Central: 2% RWJF Funds, 10% U.S. Population
East South Central: 8% RWJF Funds, 6% U.S. Population
South Atlantic: 19% RWJF Funds, 15% U.S. Population
Chart 11

Appropriations for Programs in New Jersey, 1972-1978

$ 8.7 million  New Brunswick*

*The Foundation retains a historic and continuing interest in the New Brunswick area, the original site of the Foundation.

6%—$18.3 million

9.6 million  Other New Jersey

RWJF 7-year appropriations: $318.5 million
Division of Appropriations Between Public and Private Institutions, 1972-1978

RWJF 7-year appropriations: $318.5 million

Public 35%

Private 65%
<table>
<thead>
<tr>
<th>Type of Institution</th>
<th>Number of Institutions</th>
<th>Percent of Dollars Appropriated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic health science centers</td>
<td>125</td>
<td>49%</td>
</tr>
<tr>
<td>Community and state health agencies</td>
<td>78</td>
<td>14%</td>
</tr>
<tr>
<td>Community hospitals</td>
<td>66</td>
<td>11%</td>
</tr>
<tr>
<td>National organizations</td>
<td>36</td>
<td>6%</td>
</tr>
<tr>
<td>Independent research groups</td>
<td>33</td>
<td>6%</td>
</tr>
<tr>
<td>Community clinics</td>
<td>35</td>
<td>5%</td>
</tr>
<tr>
<td>Other universities and colleges</td>
<td>22</td>
<td>3%</td>
</tr>
<tr>
<td>Major teaching hospitals</td>
<td>17</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>3%</td>
</tr>
</tbody>
</table>

RWJF 7-year appropriations: $318.5 million
Chart 14

RWJF Appropriations
Compared to Federal Health
Expenditures by Types
of Activity Supported,
1972-1978

Organization and
delivery of health
services and
manpower training
Health and
medical research
Health facility
construction
Financing health
services
Other

RWJF
Federal government
Chart 15

RWJF Appropriations Compared to Health Expenditures by Other Foundations and the Federal Government, 1976

*Data on other foundations' health expenditures are only available for 1976.
Financial statements
The annual financial statements for the Foundation appear on the following pages. A listing of grants authorized during 1978 appears on pages 71 through 79, and a summary of grants authorized in prior years which had not been paid in full as of January 1, 1978 appears on pages 80 through 94. A detailed list of investment securities held at December 31, 1978, although not included herein, is available upon request to: Communications Office, The Robert Wood Johnson Foundation, P.O. Box 2316, Princeton, New Jersey 08540.

Grants authorized in 1978, net of cancellations and refunds of prior years’ grants, totaled $44,775,631. This amount, when added to investment and administrative expenses and excise taxes for the year, exceeded income by $16,158,103. The comparable figure for 1977 was $5,863,859, and the total by which grants, expenses and taxes exceeded income for the seven years ended December 31, 1978 was $176,558,274.

Investment income for 1978 was $33,057,604, an increase of 18% over the $27,996,841 earned in 1977. Expenses in 1978 were $3,442,856, an increase of 4% over 1977.

At the beginning of 1978, the Foundation owned 8,611,086 shares of Johnson & Johnson common stock. During the year, 200,000 shares were sold, leaving a balance in the portfolio of 8,411,086 at December 31, 1978.

William R. Walsh, Jr.
Vice President and Treasurer
Opinion of Independent Certified Public Accountants

To the Trustees of
The Robert Wood Johnson Foundation:

We have examined the statement of assets, liabilities and foundation principal of The Robert Wood Johnson Foundation as of December 31, 1978, and 1977, and the related statement of investment income, expenses, grants and changes in foundation principal for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the aforementioned financial statements present fairly the financial position of The Robert Wood Johnson Foundation at December 31, 1978, and 1977, and the investment income, expenses, grants and changes in foundation principal for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Coopers & Lybrand

Newark, New Jersey,
February 1, 1979.
The Robert Wood Johnson Foundation
Statement of Assets,
Liabilities and Foundation Principal
at December 31, 1978 and 1977

<table>
<thead>
<tr>
<th>Assets</th>
<th>1978</th>
<th>1977</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$340,453</td>
<td>$293,661</td>
</tr>
<tr>
<td>Investments (at cost, or market value on dates of gifts) (Note 2):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Johnson &amp; Johnson common stock—</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8,411,086 shares in 1978, 8,611,086 shares in 1977 (quoted market value $620,317,593 and $660,900,851)</td>
<td>241,117,739</td>
<td>246,851,079</td>
</tr>
<tr>
<td>Other corporate common stocks (quoted market value $42,378,982 and $52,619,611)</td>
<td>47,405,401</td>
<td>56,786,138</td>
</tr>
<tr>
<td>Fixed income investments (quoted market value $193,706,875 and $196,066,055)</td>
<td>213,257,384</td>
<td>202,781,993</td>
</tr>
<tr>
<td>Land, building, furniture and equipment at cost, net of depreciation (Note 1)</td>
<td>6,218,146</td>
<td>6,117,685</td>
</tr>
<tr>
<td></td>
<td>$508,339,123</td>
<td>$512,830,556</td>
</tr>
</tbody>
</table>

Liabilities and Foundation Principal
Liabilities:

<table>
<thead>
<tr>
<th>Liabilities</th>
<th>1978</th>
<th>1977</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unpaid grants (Note 1)</td>
<td>$96,580,851</td>
<td>$92,403,985</td>
</tr>
<tr>
<td>Federal excise tax payable (Note 3)</td>
<td>673,592</td>
<td>1,111,732</td>
</tr>
<tr>
<td>Total liabilities</td>
<td>97,254,443</td>
<td>93,515,717</td>
</tr>
<tr>
<td>Foundation Principal</td>
<td>411,084,680</td>
<td>419,314,839</td>
</tr>
<tr>
<td></td>
<td>$508,339,123</td>
<td>$512,830,556</td>
</tr>
</tbody>
</table>

See notes to financial statements, page 70.
The Robert Wood Johnson Foundation  
Statement of Investment Income, Expenses, Grants and Changes in Foundation Principal  
for the years ended December 31, 1978 and 1977

<table>
<thead>
<tr>
<th></th>
<th>1978</th>
<th>1977</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Investment income:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dividends</td>
<td>$16,558,812</td>
<td>$14,915,762</td>
</tr>
<tr>
<td>Interest</td>
<td>16,498,792</td>
<td>13,081,079</td>
</tr>
<tr>
<td></td>
<td>33,057,604</td>
<td>27,996,841</td>
</tr>
<tr>
<td>Less: Federal excise tax (Note 3)</td>
<td>654,294</td>
<td>1,109,731</td>
</tr>
<tr>
<td>Investment expenses</td>
<td>342,926</td>
<td>253,589</td>
</tr>
<tr>
<td></td>
<td>32,060,384</td>
<td>26,633,521</td>
</tr>
<tr>
<td><strong>Expenses:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program development and evaluation</td>
<td>2,618,498</td>
<td>2,581,505</td>
</tr>
<tr>
<td>General administration</td>
<td>824,358</td>
<td>725,960</td>
</tr>
<tr>
<td></td>
<td>3,442,856</td>
<td>3,307,465</td>
</tr>
<tr>
<td><strong>Income available for grants</strong></td>
<td>28,617,528</td>
<td>23,326,056</td>
</tr>
<tr>
<td><strong>Grants, net of refunds and cancellations</strong></td>
<td>44,775,631</td>
<td>29,189,915</td>
</tr>
<tr>
<td><strong>Excess of expenses and grants over investment income</strong></td>
<td>16,158,103</td>
<td>5,863,859</td>
</tr>
<tr>
<td><strong>Additions to Foundation Principal:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net capital gains on sale of securities (Note 4)</td>
<td>7,206,559</td>
<td>6,291,694</td>
</tr>
<tr>
<td>Less related federal excise tax (Note 3)</td>
<td>19,298</td>
<td>2,001</td>
</tr>
<tr>
<td>Contributions received</td>
<td>7,187,261</td>
<td>6,289,693</td>
</tr>
<tr>
<td></td>
<td>740,683</td>
<td>785,634</td>
</tr>
<tr>
<td></td>
<td>7,927,944</td>
<td>7,075,327</td>
</tr>
<tr>
<td><strong>Net (decrease) increase in Foundation Principal</strong></td>
<td>(8,230,159)</td>
<td>1,211,468</td>
</tr>
<tr>
<td><strong>Foundation Principal, beginning of year</strong></td>
<td>419,314,839</td>
<td>418,103,371</td>
</tr>
<tr>
<td><strong>Foundation Principal, end of year</strong></td>
<td>$411,084,680</td>
<td>$419,314,839</td>
</tr>
</tbody>
</table>

See notes to financial statements, page 70.
Notes to financial statements

1. Summary of significant accounting policies:

   Grants are recorded as payable in the year the grant requests are authorized by the Board of Trustees. At December 31, 1978, unpaid grants are as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount Unpaid at December 31, 1978</th>
</tr>
</thead>
<tbody>
<tr>
<td>1974</td>
<td>$9,170,865</td>
</tr>
<tr>
<td>1975</td>
<td>9,995,347</td>
</tr>
<tr>
<td>1976</td>
<td>15,748,741</td>
</tr>
<tr>
<td>1977</td>
<td>19,660,547</td>
</tr>
<tr>
<td>1978</td>
<td>42,005,351</td>
</tr>
<tr>
<td></td>
<td><strong>$96,580,851</strong></td>
</tr>
</tbody>
</table>

   Depreciation of $169,297 in 1978 and $151,576 in 1977 is calculated using the straight-line method over the estimated useful lives of the depreciable assets.

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

2. The quoted market values of investments, particularly in the case of the sizeable holding of Johnson & Johnson common stock, may be greater than the realizable values of such investments.

3. The federal excise tax rate was 2% in 1978 and 4% in 1977.

4. The net capital gains (losses) on sales of securities for the years ended December 31, 1978 and 1977 were as follows:

<table>
<thead>
<tr>
<th>1978</th>
<th>1977</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johnson &amp; Johnson common stock</td>
<td>$9,221,122</td>
</tr>
<tr>
<td>Other securities, net</td>
<td>(2,014,563)</td>
</tr>
<tr>
<td><strong>$7,206,559</strong></td>
<td><strong>$6,291,694</strong></td>
</tr>
</tbody>
</table>

5. Substantially all employees of the Foundation are covered by a retirement plan which provides for retirement benefits through the purchase of individually-owned annuities. The Foundation's policy is to fund costs accrued. Pension expense approximated $142,400 and $134,500 in 1978 and 1977, respectively.

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<table>
<thead>
<tr>
<th>Organization</th>
<th>Project Description</th>
<th>1978 grants authorized</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Alaska, Anchorage, Alaska</td>
<td>Rural health aide training program (ID#3790)</td>
<td>$164,694</td>
</tr>
<tr>
<td>American Academy of Pediatrics, Evanston, Illinois</td>
<td>Study of pediatric training programs (ID#4643)</td>
<td>16,626</td>
</tr>
<tr>
<td>American Association of Dental Schools, Washington, D.C.</td>
<td>Develop curriculum guidelines for teaching dental care of the handicapped (ID#4529)</td>
<td>6,470</td>
</tr>
<tr>
<td>American College of Physicians, Philadelphia, Pennsylvania</td>
<td>Support of the Society for Research and Education in Primary Care Medicine (ID#4260)</td>
<td>129,056</td>
</tr>
<tr>
<td>American Fund for Dental Health, Chicago, Illinois</td>
<td>Administration of the Foundation's program to train dentists in the care of the handicapped (ID#4353)</td>
<td>17,294</td>
</tr>
<tr>
<td></td>
<td>Program to improve dental care of the handicapped (ID#4207)</td>
<td>24,900</td>
</tr>
<tr>
<td></td>
<td>Preventive dental care program for school-age children (ID#4770)</td>
<td>858,289</td>
</tr>
<tr>
<td>University of Arizona, College of Medicine, Tucson, Arizona</td>
<td>Special follow-up of high risk neonates (ID#4682)</td>
<td>563,594</td>
</tr>
<tr>
<td>Association of Science-Technology Centers, Washington, D.C.</td>
<td>Development of teaching materials in health (ID#4302)</td>
<td>176,915</td>
</tr>
<tr>
<td>Association of University Programs in Health Administration, Washington, D.C.</td>
<td>Summer internship program in health services management (ID#3821)</td>
<td>299,962</td>
</tr>
<tr>
<td>Organization</td>
<td>City, State</td>
<td>Program Description</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Barrio Comprehensive Child Care Center</td>
<td>San Antonio, Texas</td>
<td>Primary care service program for Mexican-American children (ID#3834)</td>
</tr>
<tr>
<td>Boston University</td>
<td>Boston, Massachusetts</td>
<td>Developmental assistance for independent practice associations (ID#4265)</td>
</tr>
<tr>
<td>Boston University, School of Medicine</td>
<td>Boston, Massachusetts</td>
<td>Study of child health care problems (ID#4398)</td>
</tr>
<tr>
<td>Town of Brookline, Massachusetts, Public Schools</td>
<td>Brookline, Massachusetts</td>
<td>Health program for infants and preschool children (ID#4545)</td>
</tr>
<tr>
<td>Case Western Reserve University, School of Medicine</td>
<td>Cleveland, Ohio</td>
<td>Study of child health care problems (ID#4342)</td>
</tr>
<tr>
<td>Case Western Reserve University, School of Medicine</td>
<td>Cleveland, Ohio</td>
<td>Special follow-up of high risk neonates (ID#4789)</td>
</tr>
<tr>
<td>Center for Law and Social Policy</td>
<td>Washington, D.C.</td>
<td>Survey of school nurse practitioner legislation (ID#4542)</td>
</tr>
<tr>
<td>Child Advocacy Services Center</td>
<td>Kansas City, Missouri</td>
<td>Establishment of a therapeutic nursery for abused children (ID#4286)</td>
</tr>
<tr>
<td>Children’s Hospital Medical Center</td>
<td>Boston, Massachusetts</td>
<td>Study of child health care problems (ID#4293)</td>
</tr>
<tr>
<td></td>
<td>Administrative grant for senior program consultant services (ID#4723)</td>
<td>122,073</td>
</tr>
<tr>
<td>Columbia University</td>
<td>New York, New York</td>
<td>Evaluation of the Foundation’s Municipal Health Services Program (ID#4027)</td>
</tr>
<tr>
<td>The Community Hospital Group, Inc.</td>
<td>Edison, New Jersey</td>
<td>Support of equipment needs of the Robert Wood Johnson, Jr. Rehabilitation Institute (ID#4627)</td>
</tr>
<tr>
<td>Organization</td>
<td>Grant Amount</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>Appalachian Regional Hospitals, Inc., West Liberty, Kentucky</td>
<td>$483,980</td>
<td></td>
</tr>
<tr>
<td>Marion County Hospital Authority, Buena Vista, Georgia</td>
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<td>Providence Hospital, Washington, D.C.</td>
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<td>St. Joseph Mercy Hospital, Ann Arbor, Michigan</td>
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<td>University of Connecticut Health Center, Hartford, Connecticut</td>
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<td>Cornell University, Medical College, New York, New York</td>
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<td>University of Alabama, School of Dentistry, Birmingham, Alabama</td>
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<td>Columbia University, School of Dental and Oral Surgery, New York, New York</td>
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<td>University of Kentucky, College of Dentistry, Lexington, Kentucky</td>
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<td>University of Maryland, School of Dentistry, Baltimore, Maryland</td>
<td>3,600</td>
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<td>University of Washington, Seattle, School of Dentistry, Seattle, Washington</td>
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<td>Case Western Reserve University, School of Medicine, Cleveland, Ohio</td>
<td>538,503</td>
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<td>University of Missouri, Columbia, School of Medicine, Columbia, Missouri</td>
<td>654,944</td>
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<td>Institution</td>
<td>Proposal</td>
<td>Amount</td>
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<td>University of Florida, College of Medicine</td>
<td>Program to train physicians in primary care (ID#4808)</td>
<td>$449,794</td>
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<td>Georgetown University, Graduate School</td>
<td>Completion of a monograph on the Legis 50 program to strengthen the role of state legislatures in health (ID#4393)</td>
<td>$3,379</td>
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<td>Georgetown University, School of Medicine</td>
<td>Expansion of a primary care prepaid group practice program (ID#4259)</td>
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<td>Good Samaritan Hospital and Medical Center</td>
<td>Analysis of health policy issues (ID#4194)</td>
<td>$174,702</td>
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<td>Primary care training for emergency nurses (ID#4512)</td>
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<td>State-of-the-art paper on strategic interventions in health education (ID#4327)</td>
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<td>Design of a study of a primary care-oriented reimbursement program (ID#4351)</td>
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<td>Hermann Hospital Estate</td>
<td>Primary care training for emergency nurses (ID#4078)</td>
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<td>Indiana University Foundation</td>
<td>Program to prepare clinical nursing faculty in primary care (ID#3844)</td>
<td>$240,029</td>
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<td>The Johns Hopkins Hospital</td>
<td>Foster family care program for the frail elderly (ID#4617)</td>
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<td>The Johns Hopkins University, Center for Health Services Research and Development</td>
<td>Evaluation of the Foundation's perinatal program (ID#4023)</td>
<td>$795,000</td>
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<td>Johns Hopkins University, School of Medicine</td>
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<td>Program to prepare faculty in emergency medicine (ID#3206)</td>
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<td>Joint study of surgical services in the United States (ID#4503)</td>
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<td>Study of evaluation tools to select medical school applicants (ID#3811)</td>
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<td>Publication of a manual on emergency medical communications systems (ID#4574)</td>
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<td>The Johns Hopkins University, School of Hygiene and Public Health</td>
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<td>Baltimore, Maryland</td>
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<td>Study of child health care problems (ID#4601)</td>
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<td>Maricopa County General Hospital Research Foundation</td>
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<td>Phoenix, Arizona</td>
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<td>Primary care training for emergency nurses (ID#3876)</td>
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<td>Middlesex County College</td>
<td>18,572</td>
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<td>Edison, New Jersey</td>
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<td>Refresher training to return inactive RN's to nursing service (ID#4476)</td>
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<td>Health sciences scholarship program (ID#3303)</td>
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<td>Middlesex General Hospital</td>
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<td>Property acquisitions (ID#4912 and 4405)</td>
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<td>Patient equipment support (ID#3822)</td>
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<td>Mount Sinai School of Medicine</td>
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<td>Administrative grant for senior program consultant services (ID#3840)</td>
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<td>Municipal Health Services Program</td>
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<td>Program to expand municipally-sponsored inner-city health services (ID#3960)</td>
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<td>City of Baltimore, Maryland</td>
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<td>City of Cincinnati, Ohio</td>
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<td>City of Milwaukee, Wisconsin</td>
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<td>City of St. Louis, Missouri</td>
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<td>City of San Jose, California</td>
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<td>National Academy of Sciences, Institute of Medicine</td>
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<td>Support of the Institute of Medicine (ID#3836)</td>
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<td>Fellowships in health policy program (ID#4496)</td>
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<td>Program</td>
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<td>National Association of School Nurses, Inc.</td>
<td><em>Program to improve the physical assessment and patient management skills of school nurses (ID#4427)</em></td>
<td>$25,000</td>
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<td>The National Council on the Aging, Inc.</td>
<td><em>Expand health care services for the elderly (ID#4696)</em></td>
<td>350,000</td>
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<td>National Fund for Medical Education</td>
<td><em>Support of summer programs for minority premedical students (ID#4474)</em></td>
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<td>Nebraska Methodist Hospital</td>
<td><em>Primary care training for emergency nurses (ID#4689)</em></td>
<td>306,113</td>
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<td>City of New Brunswick</td>
<td><em>Development of a regionalized EMS system (ID#3674)</em></td>
<td>200,060</td>
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<tr>
<td>University of North Carolina, School of Medicine</td>
<td><em>Publication of a study of primary care health centers (ID#3817)</em></td>
<td>63,706</td>
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<tr>
<td>University of North Carolina, School of Public Health</td>
<td><em>Study of rural health care initiatives (ID#4080)</em></td>
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<td>University of North Carolina, School of Public Health</td>
<td><em>Role of state and local health departments in ambulatory care (ID#4344)</em></td>
<td>121,732</td>
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<td>Northwestern University</td>
<td><em>Research on the management of ambulatory care services (ID#4429)</em></td>
<td>225,000</td>
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<td>Pace University, Graduate School of Nursing</td>
<td><em>Graduate program in primary care nursing (ID#3839)</em></td>
<td>350,030</td>
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<td>University of Pennsylvania, School of Medicine</td>
<td><em>Study of alternative systems for ambulatory care of the chronically ill (ID#4783)</em></td>
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<td>Institution</td>
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<td>University of Pennsylvania, School of Nursing</td>
<td>Graduate program in primary care nursing (ID#4271)</td>
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<td>Princeton Area United Community Fund</td>
<td>Annual contribution (ID#3858)</td>
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<td>Provident Hospital and Training School Association</td>
<td>Planning a hospital-sponsored ambulatory care program (ID#4232)</td>
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<td>The Rand Corporation</td>
<td>Evaluation of a preventive dental care program for school-age children (ID#4769)</td>
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<td>Administration of the Foundation's Community Hospital Ambulatory Care Program (ID#3753)</td>
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<td>University of Rochester, School of Nursing</td>
<td>Graduate program in primary nursing (ID#4350)</td>
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<td>Support of a nurse training program (ID#4483)</td>
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<td>St. Vincent de Paul Society</td>
<td>Program of assistance to the indigent (ID#3860)</td>
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<td>Program of assistance to the indigent (ID#3859)</td>
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<td>Organization</td>
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<td>School Health Services Program</td>
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<td><em>Program to improve school-based child health services (ID#3239)</em></td>
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<td>Colorado Department of Health</td>
<td>Denver, Colorado</td>
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<td>Bismarck, North Dakota</td>
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<tr>
<td>Utah State Board of Education</td>
<td>Salt Lake City, Utah</td>
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<td>Scranton Primary Health Care Center, Inc.</td>
<td>Scranton, Pennsylvania</td>
<td>457,931</td>
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<td><em>Development of a primary care group practice (ID#4171)</em></td>
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<td>Seton Hall University, College of Nursing</td>
<td>South Orange, New Jersey</td>
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<td><em>Program in clinical primary care nursing (ID#3701)</em></td>
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<td>South County Hospital Development Corporation</td>
<td>East Brunswick, New Jersey</td>
<td>2,040</td>
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<td><em>Planning for ambulatory care in southern Middlesex County (ID#3935)</em></td>
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<td>University of Southern California, School of Medicine</td>
<td>Los Angeles, California</td>
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<td><em>A college-medical school consortium for disadvantaged premedical students (ID#4219)</em></td>
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<td>University of Tennessee, College of Medicine</td>
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<td><em>Development of a regional primary care network (ID#3208)</em></td>
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<td>Tulane Medical Center</td>
<td>New Orleans, Louisiana</td>
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<td><em>Program to increase minority enrollment in medical schools (ID#4478)</em></td>
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<td>United Student Aid Funds, Inc.</td>
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<td><em>Guaranteed student loan program for medical, dental, and osteopathic students (ID#3982)</em></td>
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<tr>
<td>United Way of Central Jersey, Inc.</td>
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<tr>
<td>New Brunswick, New Jersey</td>
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<td><em>Support for the 1978 campaign (ID#3861)</em></td>
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<td>$ 175,000</td>
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<td>United Way of Minneapolis Area</td>
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<tr>
<td>Minneapolis, Minnesota</td>
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<td><em>Planning effort for coordinated health services to seniors (ID#4516)</em></td>
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<td>64,000</td>
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<td>The Urban Health Initiatives Program</td>
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<td><em>Grants to plan and develop expanded ambulatory care services (ID#4665)</em></td>
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<td>Charles R. Drew Postgraduate Medical School</td>
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<tr>
<td>Los Angeles, California</td>
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<td>600,000</td>
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<tr>
<td>Louisiana State University, New Orleans</td>
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<td>New Orleans, Louisiana</td>
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<td>633,662</td>
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<td>Montefiore Hospital and Medical Center</td>
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<td>Sisters of Mercy Health Corporation</td>
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<tr>
<td>Farmington Hills, Michigan</td>
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<td>640,650</td>
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<td>Vanderbilt University, Center for Health Services</td>
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<td>Nashville, Tennessee</td>
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<td><em>Program to improve rural community health services (ID#3838)</em></td>
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<td>Vanderbilt University, School of Medicine</td>
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<td>Nashville, Tennessee</td>
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<td><em>Planning for a primary care center (ID#3673)</em></td>
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<td>Virginia Commonwealth University</td>
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<td>Richmond, Virginia</td>
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<td><em>Administration of the Foundation's Hospital-Sponsored Ambulatory Dental Services Program (ID#4620)</em></td>
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<td>University of Washington, Seattle, School of Nursing</td>
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<td>Seattle, Washington</td>
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<td><em>Graduate program in primary care nursing (ID#3802)</em></td>
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<td>649,413</td>
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<tr>
<td>University of Washington, Seattle, School of Public Health and Community Medicine</td>
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<tr>
<td>Seattle, Washington</td>
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<td><em>Study of a prepaid group practice patient education program (ID#4531)</em></td>
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$47,187,875
Summary of grants
authorized in previous years,
and with unpaid balances on January 1, 1978

Adelphi University
Garden City, New York
Study of the role of nurses in primary care
1974—$290,299

University of Alabama, School of Nursing
Birmingham, Alabama
Primary care training program for emergency department nurses (ID#4077)
1977—$235,966

Alderson-Broadus College
Philippi, West Virginia
Physician’s assistants program in primary care (ID#2471)
1976—$267,986

Allegheny General Hospital
Pittsburgh, Pennsylvania
Primary care training program for emergency department nurses (ID#3036)
1977—$268,409

American Fund for Dental Health
Chicago, Illinois
Planning and implementation of a preventive dental care program for school-age children (ID#3218)
1976—$5,405,721

American Group Practice Foundation
Alexandria, Virginia
Program to equip physicians with professional management skills for group practices (ID#2128)
1976—$499,825

American Health Planning Association
Alexandria, Virginia
Technical assistance for health planning agencies
1975—$360,000

American Medical Student Association Foundation
Schaumburg, Illinois
Field service in community health for health science students (ID#2200)
1976—$318,840

Appalachian Regional Hospitals, Inc.
Hazard, Kentucky
Outreach service for the care of mothers, infants, and young children (ID#3040)
1977—$195,000; 1974—$623,619

Arizona State University, College of Nursing
Tempe, Arizona
Rural emergency medical care training program with Maricopa County Hospital (ID#0944)
1976—$294,540

Aspira of America, Inc.
New York, New York
Program to increase minority enrollment in medical schools (ID#3041)
1977—$323,308

Association of American Medical Colleges
Washington, D.C.
Program to strengthen the management capabilities of academic medical centers (ID#3164)
1977—$539,732

Workshops on financial-aid programs for medical students (ID#3804)
1977—$73,000

Association of Physician Assistant Programs
Washington, D.C.
Program with the American Academy of Physician’s Assistants to foster training of new health practitioners (ID#2485)
1976—$225,000
Association of Science-Technology Centers
Washington, D.C.
*Development of teaching materials in health (ID#2635)*
1976—$475,440

Association of University Programs in Health Administration
Washington, D.C.
*Summer internship program in health services management*
1975—$332,817

Barrio Comprehensive Child Care Center
San Antonio, Texas
*Primary care service program for Mexican-American children*
1975—$526,791

Bedford-Stuyvesant Family Health Care Center, Inc.
Brooklyn, New York
*Establishment of a primary care service program in the inner city (ID#2787)*
1977—$584,709

Bedford-Stuyvesant Restoration Corporation
Brooklyn, New York
*Planning for a primary care health center*
1975—$138,100

Beth Israel Hospital
Boston, Massachusetts
*Development of a research capability in ambulatory care*
1974—$512,337

Boston City Hospital
Boston, Massachusetts
*Program to prepare physicians and nurses for careers in general medical care*
1975—$1,189,677

Boston University
Boston, Massachusetts
*Studies in the quality of patient care*
1975—$519,729

Boys' Clubs of America
New York, New York
*Health services and education program (ID#0953)*
1977—$498,138

Town of Brookline, Massachusetts, Public Schools
Brookline, Massachusetts
*Health program for infants and preschool children (ID#2486)*
1976—$712,058

Cabin Creek Health Association
Cabin Creek, West Virginia
*Community primary care health services (ID#3039)*
1977—$176,551

University of California, Davis
School of Medicine
Davis, California
*Program for the preparation and placement of rural nurse practitioners (ID#2487)*
1976—$455,323

University of California, Los Angeles
Los Angeles, California
*Planning and conducting an evaluation of the Foundation's school health services program (ID#3133)*
1976—$619,715

University of California, Los Angeles
School of Medicine
Los Angeles, California
*Program to prepare physicians in primary care (ID#2177)*
1976—$547,625

Susan B. Anthony Children's Hospital
San Francisco, California
*Study of health decision making among children (ID#4126)*
1977—$303,461

University of California, San Francisco
School of Medicine
San Francisco, California
*Establishment of a health policy center (ID#2455)*
1976—$1,000,000
Program to prepare physicians and nurses in primary care
1975—$656,344

Program to prepare faculty in emergency medicine
1975—$715,917

Evaluation of the Foundation's Clinical Scholars Program
1975—$207,403

Analysis of programs to prepare physicians for careers in primary medical care (ID#2378)
1976—$149,417

Center for Research in Ambulatory Health Care Administration
Denver, Colorado

Financial management assistance program
(ID#3057)
1977—$353,094

University of Chicago
Chicago, Illinois

Study of the implementation of a national health insurance program
1975—$252,422

Evaluation of the Foundation's Community Hospital Ambulatory Care Program
(ID#3163)
1977—$1,151,689

Children's Hospital Medical Center
Boston, Massachusetts

Training clinical faculty in child development
(ID#2424)
1976—$450,000

Children's Research Institute of California
Sacramento, California

Study of the California child health care program (ID#2788)
1976—$286,750

Christian Action Ministry
Chicago, Illinois

Development of a community-wide health program
1975—$295,200

La Clinica de la Raza
Oakland, California

Program to improve community health services
(ID#3124)
1977—$267,185

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

Development of a mother and infant care training program
1974—$134,765

Clinical Scholars Program

National program to prepare young physicians for leadership roles in medical care
(ID#2493)

University of California, Los Angeles,
School of Medicine
Los Angeles, California
1977—$714,232; 1974—$856,103

University of California, San Francisco,
School of Medicine and Stanford
University, School of Medicine
San Francisco, California
1977—$799,673

Columbia University, College of Physicians and Surgeons
New York, New York
1977—$187,745; 1974—$829,343

George Washington University, School of Medicine
Washington, D.C.
1977—$194,502; 1974—$860,670

Johns Hopkins University, School of Medicine
Baltimore, Maryland
1977—$225,217

McGill University, McIntyre Medical Sciences Center
Montreal, Quebec
1977—$799,997
Clinical Scholars Program (continued)

University of North Carolina, School of Medicine
Chapel Hill, North Carolina
1977—$800,000

University of Pennsylvania, School of Medicine
Philadelphia, Pennsylvania
1977—$799,478

University of Washington, Seattle, School of Medicine
Seattle, Washington
1977—$600,147; 1974—$798,230

Yale University, School of Medicine
New Haven, Connecticut
1977—$799,792

Educational development funds
1974—$770,647

University of Colorado, School of Medicine
Denver, Colorado
Center for the Prevention and Treatment of Child Abuse and Neglect
1975—$1,162,655
Planning of a new medical curriculum to prepare non-M.D. primary care practitioners
1974—$155,400

Columbia University
New York, New York
Public policy program in health services and manpower by the Center for the Conservation of Human Resources (ID#2889)
1976—$333,773

Community Hospital-Medical Staff Group Practice Program

Grants for the development of hospital-sponsored primary care group practices (ID#4470)

Bethesda Lutheran Hospital
St. Paul, Minnesota
1976—$499,790

Community Hospital-Medical Staff Group Practice Program (continued)

Crittenden Memorial Hospital
West Memphis, Arkansas
1976—$494,029

Durham County Hospital Corporation
Durham, North Carolina
1976—$499,916

Griffin Hospital
Derby, Connecticut
1976—$500,000

Hadley Memorial Hospital
Washington, D.C.
1976—$457,006

Hollywood Presbyterian Hospital—Olmsted Memorial
Los Angeles, California
1976—$499,981

Holston Valley Community Hospital
Kingsport, Tennessee
1976—$466,197

Holy Cross Hospital
Salt Lake City, Utah
1976—$443,308

Humboldt General Hospital
Winnemucca, Nevada
1977—$500,000

Joint Hospital Committee for Extramural Affairs
Aberdeen, Washington
1977—$494,160

La Crosse Lutheran Hospital
La Crosse, Wisconsin
1977—$244,547

Lakewood Hospital
Lakewood, Ohio
1976—$498,020

Lovelace Center for the Health Sciences
Albuquerque, New Mexico
1976—$374,853
<table>
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<tr>
<th>Community Hospital-Medical Staff Group Practice Program (continued)</th>
<th>Community Hospital-Medical Staff Group Practice Program (continued)</th>
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<tr>
<td>Lutheran Charities Association of St. Louis, Missouri</td>
<td>New York Infirmary</td>
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<tr>
<td>St. Louis, Missouri</td>
<td>New York, New York</td>
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<td>1976—$475,105</td>
<td>1977—$500,000</td>
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<tr>
<td>Lutheran General and Deaconess Hospitals</td>
<td>Portland Adventist Hospital</td>
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<td>Park Ridge, Illinois</td>
<td>Portland, Oregon</td>
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<tr>
<td>1976—$500,000</td>
<td>1976—$492,658</td>
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<tr>
<td>Lutheran Hospital and Medical Center</td>
<td>Providence Medical Center</td>
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<tr>
<td>Wheat Ridge, Colorado</td>
<td>Seattle, Washington</td>
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<tr>
<td>1976—$500,000</td>
<td>1977—$500,000</td>
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<tr>
<td>Lutheran Hospital of Maryland, Inc.</td>
<td>Richmond Memorial Hospital</td>
</tr>
<tr>
<td>Baltimore County, Maryland</td>
<td>Richmond, Virginia</td>
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<tr>
<td>1976—$496,170</td>
<td>1976—$497,000</td>
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<tr>
<td>The Memorial Hospital</td>
<td>St. Aloisius Hospital</td>
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<tr>
<td>Worcester, Massachusetts</td>
<td>Harvey, North Dakota</td>
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<td>1976—$475,000</td>
<td>1976—$499,533</td>
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<tr>
<td>Memorial Hospital of Alamance County, Inc.</td>
<td>St. Francis Hospital</td>
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<tr>
<td>Burlington, North Carolina</td>
<td>Honolulu, Hawaii</td>
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<tr>
<td>Memorial Hospital of Phoenix</td>
<td>St. Francis Hospital</td>
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<tr>
<td>Phoenix, Arizona</td>
<td>Topeka, Kansas</td>
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<tr>
<td>1976—$498,942</td>
<td>1976—$446,296</td>
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<tr>
<td>Mercy Hospital</td>
<td>St. Joseph Hospital</td>
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<tr>
<td>Springfield, Massachusetts</td>
<td>Lancaster, Pennsylvania</td>
</tr>
<tr>
<td>1976—$490,000</td>
<td>1976—$497,620</td>
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<tr>
<td>Mercy Hospital</td>
<td>St. Joseph's Hospital and Medical Center</td>
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<tr>
<td>Watertown, New York</td>
<td>Paterson, New Jersey</td>
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<tr>
<td>1977—$500,000</td>
<td>1976—$500,000</td>
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<tr>
<td>Mercy Hospital, Inc.</td>
<td>St. Lawrence Hospital</td>
</tr>
<tr>
<td>Baltimore, Maryland</td>
<td>Lansing, Michigan</td>
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<tr>
<td>1976—$499,985</td>
<td>1977—$491,993</td>
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<tr>
<td>Nashua Hospital Association</td>
<td>St. Luke's Hospital</td>
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<td>Nashua, New Hampshire</td>
<td>Aberdeen, South Dakota</td>
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<td>1977—$500,000</td>
<td>1976—$498,169</td>
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<td></td>
<td>St. Margaret Memorial Hospital</td>
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<td>Pittsburgh, Pennsylvania</td>
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<td>1976—$401,944</td>
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</table>
Community Hospital-Medical Staff Group Practice Program (continued)

St. Vincent Hospital and Medical Center
Portland, Oregon
1977—$499,727

St. Vincent's Hospital
Billings, Montana
1976—$499,709

San Bernardino County Medical Center
San Bernardino, California
1977—$499,967

Scottsdale Memorial Hospital
Scottsdale, Arizona
1977—$498,103

Sisters of Mercy Health Corporation
Sioux City, Iowa
1977—$500,000

Herbert J. Thomas Memorial Hospital Association
South Charleston, West Virginia
1976—$485,456

Waterville Osteopathic Hospital
Waterville, Maine
1977—$467,994

Wausau Hospital, Inc.
Wausau, Wisconsin
1977—$456,117

Williamsburg County Memorial Hospital
Kingstree, South Carolina
1977—$485,185

Charles S. Wilson Memorial Hospital
Johnson City, New York
1976—$469,361

University of Connecticut Health Center
Hartford, Connecticut

Cornell University, Medical College
New York, New York

Planning for ambulatory care
1973—$499,000

Study of doctor-patient communications (ID#2473)
1976—$243,091

Administration of the Foundation's Municipal Health Services Program (ID#3791)
1977—$208,390

Dartmouth College, Medical School
Hanover, New Hampshire

Development of a primary care service and training program
1974—$1,154,685

Dental Training Program
Grants to dental schools to train dentists in the care of the handicapped

University of Alabama, School of Dentistry
Birmingham, Alabama
1973—$432,651

University of California, Los Angeles, School of Dentistry
Los Angeles, California
1973—$435,351

Columbia University, School of Dental and Oral Surgery
New York, New York
1973—$357,842

University of Kentucky, College of Dentistry
Lexington, Kentucky
1973—$420,746

University of Maryland, School of Dentistry
Baltimore, Maryland
1973—$466,992

University of Michigan, School of Dentistry
Ann Arbor, Michigan
1973—$394,481

University of Nebraska, School of Dentistry
Lincoln, Nebraska
1973—$466,930

Development of a school-based health care program
1975—$618,557
Dental Training Program (continued)

New York University, College of Dentistry, The Brookdale, Long Island Dental Center New York, New York
1973—$415,940

University of Tennessee, College of Dentistry Memphis, Tennessee
1973—$469,876

University of Washington, Seattle, School of Dentistry Seattle, Washington
1973—$441,509

Duke University, School of Medicine Durham, North Carolina

*Faculty training and research program in family medicine*
1975—$802,885

East Kentucky Health Services Center, Inc. Hindman, Kentucky

*Expansion of a nonprofit rural group practice*
1975—$344,050

ECCO Family Health Center Columbus, Ohio

*Expansion of an ambulatory health care services program (ID#2911)*
1976—$392,987

Educational Testing Service Princeton, New Jersey

*Planning and development of a program to evaluate the Foundation's dental training program for the care of the handicapped*
1974—$300,530

Emergency Medical Response Program

*Grants to communities developing regional systems*

Hunterdon County Board of Chosen Freeholders Flemington, New Jersey
1974—$319,453

Emergency Medical Response Program (continued)

Idaho Department of Environmental and Community Services Boise, Idaho
1973—$399,851

King County Board of Commissioners Seattle, Washington
1973—$362,000

The Navajo Health Authority Window Rock, Arizona
1973—$388,577

New Jersey State Department of Health Trenton, New Jersey
1973—$399,340

San Francisco, Department of Public Health San Francisco, California
1973—$338,330

Municipality of San Juan San Juan, Puerto Rico
1973—$212,640

University of Utah Salt Lake City, Utah
1973—$340,432

University of Virginia Charlottesville, Virginia
1973—$322,626

Family Practice Faculty Fellowship Program

*Program to prepare physicians for academic careers in family practice*

University of Iowa, College of Medicine
Iowa City, Iowa
1977—$781,051

University of Utah, College of Medicine Salt Lake City, Utah
1977—$587,601

University of Washington, Seattle, School of Medicine Seattle, Washington
1977—$623,832
University of Florida, College of Medicine
Gainesville, Florida

*Primary care training and service program*
1975—$870,371

The Foundation Center
New York, New York

*Data collection and analysis on the foundation field (ID#3486)*
1977—$150,000

Foundation for Comprehensive Health Services
Sacramento, California

*Primary care delivery for rural California (ID#3789)*
1977—$475,000

Frontier Nursing Service
Wendover, Kentucky

*Expansion of a nurse-run primary care network*
1975—$508,360

Fund for the City of New York
New York, New York

*Program to improve the quality of care in municipal hospitals (ID#2708)*
1976—$150,000

Genesee Hospital
Rochester, New York

*Expansion of an ambulatory care program*
1973—$187,000

George Washington University
Washington, D.C.

*Seminar program for government health staff professionals (ID#3117)*
1977—$575,000

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

*Program to train physicians and nurses in primary care (ID#2474)*
1977—$24,492; 1973—$600,000

Georgetown University, Graduate School
Washington, D.C.

*Planning and development of a health policy center*
1974—$1,328,734

*Completion of a monograph on the Legis 50 program to strengthen the role of state legislatures in health (ID#4132)*
1977—$14,350

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

*Administrative grant for senior program consultant services (ID#3903)*
1977—$157,985

*Analysis of health policy issues (ID#3805)*
1977—$163,364

Group Health Foundation
Washington, D.C.

*Program with the University of Pennsylvania to prepare managers for prepaid group practices*
1974—$48,000

*Program to equip physicians with professional management skills for HMOs (ID#2107)*
1976—$299,585

Harvard University, Medical School
Boston, Massachusetts

*Program to train physicians for primary medical care (ID#3089)*
1977—$733,788; 1973—$337,644

Harvard University, School of Public Health
Cambridge, Massachusetts

*Support of the School of Public Health (ID#3107)*
1976—$1,000,000

Health Care Institute, Inc.
Detroit, Michigan

*Development of a primary care service and education program (ID#2042)*
1977—$176,820
Health Care Management Systems, Inc.
La Jolla, California
*Development of information systems for ambulatory care*
1974—$396,152

Hospital Research and Educational Trust
Chicago, Illinois
*Study of the role of public hospitals in ambulatory care (ID#2412)*
1976—$325,000

Hyde Park-Kenwood Community Health Center, Inc.
Chicago, Illinois
*Development of a primary care health services program (ID#3269)*
1977—$238,825

Indiana University Foundation
Bloomington, Indiana
*Program to prepare clinical nursing faculty in primary care (ID#3844)*
1975—$297,653

The Johns Hopkins Hospital
Baltimore, Maryland
*Administration of the Foundation's Municipal Health Services Program (ID#4323)*
1977—$189,000

The Johns Hopkins University
Baltimore, Maryland
*School of health services training program*
1975—$3,000,000

The Johns Hopkins University, Center for Health Services Research and Development
Baltimore, Maryland
*Evaluation of the Foundation's perinatal program*
1974—$2,013,220

The Johns Hopkins University, School of Medicine
Baltimore, Maryland
*Program to prepare faculty in emergency medicine*
1974—$754,272

Study of evaluation tools to select medical school applicants (ID#2714)
1976—$130,473

Joint Commission of Accreditation of Hospitals
Chicago, Illinois
*Ambulatory health care services accreditation program (ID#2428)*
1976—$338,165

Lake Erie College
Painesville, Ohio
*Program with the Cleveland Clinic to train physician's assistants*
1975—$526,853

Massachusetts Institute of Technology,
Alfred P. Sloan School of Management
Cambridge, Massachusetts
*Program to improve primary care team skills*
1974—$440,449

University of Massachusetts
Worcester, Massachusetts
*Program to improve methods for evaluating the quality of health care services*
1975—$225,191

Mayo Foundation
Rochester, Minnesota
*Development of a primary care satellite network (ID#3809)*
1977—$350,000

The Medical Center at Princeton
Princeton, New Jersey
*Facility expansion (ID#4303)*
1977—$20,000

Medical Center of Gary, Inc.
Gary, Indiana
*Program to train family health practitioners*
1975—$300,000

Medical Mission Sisters
Philadelphia, Pennsylvania
*Program of primary care services for rural and urban communities (ID#3119)*
1977—$257,920
Meharry Medical College
Nashville, Tennessee

Faculty development program (ID#3216)
1977—$2,500,000

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

Program on health manpower development (ID#2479)
1976—$424,911

Middlesex General Hospital
New Brunswick, New Jersey

Support for the Hospital's Family Health Center (ID#4063)
1977—$144,200

University of Mississippi Medical Center
Jackson, Mississippi

Program to increase minority enrollment in medical schools (ID#2296)
1976—$433,705

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

Program to prepare physicians and nurses for careers in general medical care
1974—$901,670

Montefiore Hospital and Medical Center
Bronx, New York

Training physicians and other professionals in team practice
1975—$584,877

Development of a child care program with the Martin Luther King Health Center
1975—$579,530

Morehead Clinic
Morehead, Kentucky

Development of primary care satellite clinics in northeast Kentucky
1974—$245,860

Morehouse College
Atlanta, Georgia

Program to increase minority enrollment in medical schools (ID#2716)
1976—$471,225

Mount Sinai School of Medicine
New York, New York

Program to develop primary care services for children (ID#3792)
1977—$150,000

Administrative grant for senior program consultant services (ID#3235)
1977—$183,803

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

Fellowships in health policy program
1975—$1,215,040

Support of the Institute of Medicine
1975—$850,000

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

Administration of the Foundation's regional emergency medical response program
1975—$360,000

Support of the Academy's Emergency Medical Services Committee
1975—$274,200

National Association of Health Services Executives
New York, New York

Program to assist minority health administrators
1975—$232,862

National Board of Medical Examiners
Philadelphia, Pennsylvania

Program to complete the development of a computer-based license examination (ID#2576)
1977—$475,000
National Bureau of Economic Research  
New York, New York  
*Research and training program in health economics (ID#3081)*  
1976—$274,091

National Chamber Foundation  
Washington, D.C.  
*Program to study national health care issues (ID#3964)*  
1977—$5,000

National 4-H Council  
Chevy Chase, Maryland  
*Health education program development (ID#2754)*  
1977—$201,308

National Fund for Medical Education  
Hartford, Connecticut  
*Support of summer programs for minority premedical students (ID#2583)*  
1976—$160,000

National League for Nursing  
New York, New York  
*Summer study program in health policy (ID#3121)*  
1977—$145,684

National Medical Fellowships  
New York, New York  
*Scholarship program for minority medical students (ID#2929)*  
1976—$1,000,000

National Rural Center  
Washington, D.C.  
*Analysis of the financial needs of service programs in rural areas (ID#3362)*  
1977—$234,951

New Brunswick Tomorrow  
New Brunswick, New Jersey  
*City of New Brunswick redevelopment program (ID#3614)*  
1977—$1,500,000

New England Medical Center Hospital  
Boston, Massachusetts  
*Study of decision making in the health care system*  
1975—$149,880

College of Medicine and Dentistry of New Jersey  
Newark, New Jersey  
*Planning for training and service programs*  
1973—$493,000

College of Medicine and Dentistry of New Jersey, Rutgers Medical School  
Piscataway, New Jersey  
*Program to prepare minority students for preprofessional careers in medicine and dentistry (ID#2795)*  
1976—$264,592

University of North Carolina, School of Medicine  
Chapel Hill, North Carolina  
*Administration of the Foundation’s rural community practice models program*  
1975—$2,074,081

University of Colorado Medical Center, School of Nursing  
Denver, Colorado  
1975—$675,000

Indiana University Foundation  
Indianapolis, Indiana  
1975—$675,000
Nurse Faculty Fellowships Program (continued)

University of Maryland, School of Nursing
Baltimore, Maryland
1975—$675,000

University of Rochester, School of Nursing
Rochester, New York
1975—$665,054

Vanderbilt University, School of Nursing
Nashville, Tennessee
Administration of the Program
1975—$282,236

University of Oregon Health Sciences Center,
School of Nursing
Portland, Oregon
Data collection and analysis of the Foundation’s
Nurse Faculty Fellowships Program
(ID#3296)
1976—$123,947

Pace University, Graduate School of Nursing
New York, New York
Graduate program in primary care nursing
(ID#2029)
1977—$162,550

University of Pennsylvania
Philadelphia, Pennsylvania
Study of chronic care, in association with
Middlesex General Hospital, New Brunswick,
New Jersey (ID#3217)
1977—$310,105

University of Pennsylvania, School of
Dental Medicine
Philadelphia, Pennsylvania
Dental care program for school-age children in
rural Pennsylvania (ID#3837)
1977—$547,000; 1975—$2,023,854

University of Pennsylvania, School of Medicine
Philadelphia, Pennsylvania
Program to train physicians for careers in
primary care (ID#1499)
1977—$401,765

Perinatal Program

Grants for the development of regional high-risk
pregnancy networks

Arizona Medical Association Foundation
Phoenix, Arizona
1974—$2,200,000

Case Western Reserve University,
School of Medicine
Cleveland, Ohio
1974—$2,225,000

Columbia University, College of
Physicians and Surgeons
New York, New York
1974—$2,199,925

Charles R. Drew Postgraduate
Medical School
Los Angeles, California
1974—$2,200,000

Professional Staff Association of Los Angeles
County—Harbor General Hospital
Torrance, California
1974—$2,200,000

University of Southern California
Los Angeles, California
1974—$2,198,721

State University of New York,
Upstate Medical Center
Syracuse, New York
1974—$2,176,354

University of Texas, Health Sciences Center
Dallas, Texas
1974—$2,200,000

University of Pittsburgh, School of Medicine
Pittsburgh, Pennsylvania
Expansion of a child care program (ID#2738)
1977—$35,568
Posen-Robbins School District
Oak Park, Illinois
Planning and development of a school-based health care system (ID#3305)
1977—$467,527

Princeton Area United Community Fund
Princeton, New Jersey
Annual contribution (ID#3434)
1977—$27,500

The Rand Corporation
Santa Monica, California
Evaluation of regional emergency medical response systems (ID#3122)
1977—$197,824
Planning and conducting the evaluation of a preventive dental care program for school-age children (ID#2890)
1976—$771,611

Rio Grande Federation of Health Centers
San Antonio, Texas
Support of a technical assistance program (ID#2538)
1976—$243,180

University of Rochester, School of Medicine and Dentistry
Rochester, New York
Program to train physicians for careers in primary care (ID#3090)
1977—$643,760; 1973—$1,395,000
Administration of the Foundation's Community Hospital Ambulatory Care Program (ID#3751)
1977—$567,637

Roxbury Dental and Medical Group
Roxbury, Massachusetts
Support of an urban group practice (ID#3649)
1977—$106,000

Rural Health Care Association
Denver, Colorado
Strengthening rural primary care practices in Colorado (ID#4100)
1977—$95,868

Rural Practice Project
Program to develop nonprofit group medical practices in rural areas

Associated Community Action of the North East Adirondack Region, Inc.
Willsboro, New York
1975—$480,463

Bakersville Community Medical Clinic, Inc.
Bakersville, North Carolina
1975—$288,269

Dunes Family Health Care, Inc.
Reedsport, Oregon
1975—$460,457

Family Health Care, Inc.
Tooele, Utah
1975—$443,897

Mille Lacs Family Health Foundation, Inc.
Onamia, Minnesota
1975—$483,970

Mission Valley Health Services Center, Inc.
St. Ignatius, Montana
1975—$471,616

New River Health Association, Inc.
Scarbro, West Virginia
1975—$412,331

Northeast Washington County Community Health, Inc.
Plainfield, Vermont
1975—$403,682

Palmetto Family Health Care Center, Inc.
Pacolet, South Carolina
1975—$394,075

Peninsula Family Practice, Inc.
Leland, Michigan
1975—$463,062

Roanoke-Amaranth Community Health Group, Inc.
Jackson, North Carolina
1975—$499,500
Rural Practice Project (continued)

Southern Indiana Community
Health Care, Inc.
Paoli, Indiana
1975—$398,932

Surry County Family Health Group, Inc.
Surry, Virginia
1975—$499,406

Balance of appropriation
1975—$1,300,340

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

*Study of the role of medical specialists in
primary care*
1975—$1,403,644

Stanford University Medical Center
Stanford, California

*Support of a research and training program in
ambulatory pediatrics (ID#3229)*
1977—$272,498

*Study of the training of new health practitioners
in primary care, with the University of
California, Davis (ID#2944)*
1976—$198,573

County of Suffolk, New York
Hauppauge, New York

*Study of a regionalized emergency medical
response system (ID#4160)*
1977—$146,317

Tennessee Department of Public Health
Nashville, Tennessee

*Development of a primary care center in
Hamilton County*
1975—$417,346

University of Tennessee, College of Medicine
Memphis, Tennessee

*Development of a regional primary care
network*
1974—$801,504

University of Texas, Austin
Austin, Texas

*Study of rural health service programs
(ID#2285)*
1976—$499,709

University of Texas Medical Branch at
Galveston
Galveston, Texas

*Primary care services for school-age children
(ID#2763)*
1976—$1,171,960

*Program to increase minority enrollment in
medical schools (ID#2422)*
1976—$339,268

Tulane Medical Center
New Orleans, Louisiana

*Program to increase minority enrollment in
medical schools*
1974—$618,492

Tuskegee Institute
Tuskegee, Alabama

*Development of a primary care health service
program in rural Alabama*
1975—$1,419,880

United States Conference of Mayors
Washington, D.C.

*Dissemination of health services information
(ID#4069)*
1977—$75,000

*Analysis of the financial needs of service
programs in inner-city areas (ID#3994)*
1977—$234,951

Vanderbilt University, Center for
Health Services
Nashville, Tennessee

*Program to improve rural community health
services*
1975—$312,780
Vanderbilt University, School of Nursing  
Nashville, Tennessee  
Administrative grant for senior program consultant services (ID#3641)  
1976—$99,991

Administration of the Nurse Faculty Fellowships Program (ID#3787)  
1977—$94,100

Washington University, School of Medicine  
St. Louis, Missouri  
Development of an ambulatory care teaching practice (ID#2484)  
1976—$495,400

University of Washington, Seattle  
Seattle, Washington  
Evaluation of the Foundation’s Community Hospital Ambulatory Care Program (ID#4016)  
1977—$287,438

University of Washington, Seattle, School of Medicine  
Seattle, Washington  
Study of the training of new health practitioners  
1975—$520,351

Program to train physicians for careers in primary care (ID#4272)  
1977—$554,636; 1976—$96,073

University of Wisconsin  
Madison, Wisconsin  
Study of new health practitioners in ambulatory care  
1976—$269,230

Study of new health practitioners in ambulatory care  
1974—$217,760

Yale University, School of Medicine  
New Haven, Connecticut  
Research on the structure and quality of primary pediatric care (ID#4170)  
1977—$21,965; 1973—$376,000
Secretary’s report
Staff Changes
During 1978, three senior advisers completed their assignments with the Foundation: John C. Beck, M.D., Director of The Robert Wood Johnson Clinical Scholars Program; Ann A. Bliss, Senior Program Consultant; and Robert H. Kalinowski, M.D., Senior Program Consultant.

Dr. Beck joined the Foundation in 1973 and had primary responsibility for developing and operating the Foundation's Clinical Scholars Program. He has accepted a faculty appointment at the University of California, Los Angeles, School of Medicine. Mrs. Bliss came to the Foundation in 1973 and played a major role in advising on the development of the Foundation’s service and training programs involving nurses in expanded roles for patient care. She is a Clinical Associate Professor, Department of Medicine, Yale University School of Medicine. Dr. Kalinowski also began his service to the Foundation in 1973 and was of enormous assistance in the development of university-related primary care service and training programs. He is practicing anesthesiology in Atlanta, Georgia.

Marilyn C. Farray, Program Officer, resigned her position with the Foundation to enter law school at Yale University. Ms. Farray joined the Foundation staff in 1975 and was active in the development of the Foundation's Municipal Health Services Program.

Charles R. Buck, Jr., Sc.D., was appointed in January of 1978 to be Director of the Municipal Health Services Program. He guided this program through its initial stage of making grants to five of the nation's largest cities to help them in providing needy urban neighborhoods with a ready source of general medical care. Dr. Buck left the Foundation in January 1979 to become Secretary of Health of the State of Maryland. Succeeding Dr. Buck as Senior Program Consultant directing the Municipal Health Services Program is Carl J. Schramm, Ph.D., J.D. Dr. Schramm is an Assistant Professor in the Department of Health Services Administration, School of Hygiene and Public Health of The Johns Hopkins University. He received his doctorate from the University of Wisconsin and his law degree from Georgetown University Law Center.

M. Alfred Haynes, M.D., was appointed Coordinator of the Foundation’s Clinical Scholars Program in March 1978. Dr. Haynes is President of Instudhess, Inc. and has previously served as Chairman, Department

*To present as up-to-date a picture of staffing as possible, this report covers the period through February 15, 1979.*
of Community Medicine, and Associate Dean, Charles R. Drew Postgraduate Medical School, Los Angeles, California.

Joining the Foundation in June 1978 as a Senior Program Consultant was Robert J. Haggerty, M.D. Dr. Haggerty will direct the Foundation’s General Pediatrics Academic Development Program. He is a Visiting Professor of Pediatrics, Harvard Medical School, Professor of Public Health, Harvard School of Public Health, and Senior Associate in Medicine, Children’s Hospital Medical Center, Boston, Massachusetts.

In June 1978 John J. Salley, D.D.S., Ph.D., was appointed Senior Program Consultant to administer the Foundation’s hospital-sponsored dental program. Dr. Salley is Associate Vice President for Research and Graduate Affairs and Professor of Oral Pathology, School of Dentistry and School of Medicine at Virginia Commonwealth University, Richmond, Virginia.

Martita M. Marx, Dr.P.H. joined the staff as a Program Officer in the fall of 1978. Dr. Marx received her doctoral degree from the University of California, Los Angeles and previously served as a consultant in applied research with Practical Concepts, Inc. of Washington, D.C.

Marc E. Voyvodich came to the Foundation as a Program Officer in October from the Blue Cross Association in Chicago, Illinois, where he worked as Assistant to the President. Mr. Voyvodich is a graduate of Colgate University and received his Master of Arts in Health Care Administration from George Washington University.

Eleanor O’D. Nealon joined the Foundation’s Communications Office in May as an Information Services Officer. Ms. Nealon previously worked as a freelance writer in Washington, D.C., and is a former Director of Public Relations for the Georgetown University Medical Center.

Board Activities
The Board of Trustees met six times in 1978 to conduct business, review proposals, and appropriate funds for the implementation of new programs. In addition, the Policy, Finance, and Audit Committees met as required to consider and prepare recommendations to the Board.

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

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

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

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

Also, the Foundation will not be able to support programs concerned with a particular disease or with broad public health problems such as drug abuse, alcoholism, mental health, population dynamics, 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.

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.