The
Robert Wood Johnson Foundation
Annual Report 1984
January 1, 1984 through December 31, 1984
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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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Washington, D.C.
The president’s statement
In last year's Annual Report I suggested that a whole series of new developments were converging to create great pressures for change in our ways of delivering medical care to people in this country. Among them I listed rapid shifts in our ways of paying hospitals, a potential surplus of physicians, rapidly advancing technologies permitting much more care to be given outside the hospital, and a changing demography shown in the progressive aging of the United States. I further indicated that accelerating the process was a public sense of alarm and even anger about the dizzying escalation of medical care costs.

The passage of the year has made me realize my predictions, while on target, were too conservative. Our health care system is changing so fast, so fundamentally, and going in so many different and even contradictory directions, that health professionals and those who work with them are having a very hard time following it all. Interestingly, those who go to doctors as patients have not yet sensed the profound upheaval, but this realization will surely come soon.

It has been our Foundation's feeling since the outset, a feeling yet more intense today, that we could be most useful and effective, particularly in a climate of flux and uncertainty, if we focused our resources on only a few problems at a time. We have tried to select those that have loomed large in public importance, while trying to keep track of what changing health care arrangements mean for people's medical care. Thus, we have continued to work on the general agenda outlined over the last several years.

During 1984 we have put more emphasis in four areas that we believe to be of key public importance. They are:

- slowing the rate of increase in health care costs;
- improving the health and survival of newly born infants;
- improving the ability of the frail elderly to maintain function and independence; and
- improving access to medical care for those groups most seriously underserved within present health care arrangements.

As part of this latter theme, we have also attempted to "keep book" on which groups or segments of our society are having the most difficulties in obtaining necessary medical care during this period of rapid change. Let me describe what we have learned about each of these areas in more detail.
Slowing the nation’s rising health care costs

For the first time in a number of years, 1983 saw a slowdown in the rate of rise of the nation’s medical bill. Part of this was a result of the many recent cooperative expenditure reduction initiatives launched by business, government, labor, physicians, and hospitals. Much of it was also due to the overall reduction in inflation.

However, it is clear the nation still has a long way to go to bring health costs under control. From preliminary estimates, Americans spent $384.3 billion for health care in 1984, an 8.1 percent increase over what we spent in 1983.\(^1\) Although this rise represents the lowest annual rate of increase seen during the last decade, health care costs have continued to rise more swiftly than the overall economy. In 1984, health care used up approximately $135.3 billion more dollars a year than it did in 1980 when our foundation, along with many other larger players on the scene, chose to focus attention on this problem.\(^2\) In fact, the United States spent about $1,500 per person for health care in 1984 while Japan spent $500, Great Britain $400, France $800, and West Germany $900.\(^3\)

Of yet more concern, the forecasts on future expenditures continue to look dreadful. As shown in Figure 1, independent projections suggest that despite present efforts, the nation’s health spending will continue to increase at alarming rates, rising from $384.3 billion in 1984 to $690 billion in 1990, and to a staggering $1.9 trillion in the year 2000.

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**Figure 1**

Forecasted health spending, 1984-2000 (preliminary estimates)
We simply cannot let this occur. Not only would such expenditures for health rob other important social programs, but they would threaten many of the recent gains made in securing improved medical care for some of the most vulnerable in our society. Further, such costs would tend to exacerbate a number of other broad national problems, as, for example, our worrisome federal deficit, the potential bankruptcy of Medicare, the increasing inability of many states to fully fund Medicaid, and the increasing lack of competitiveness of U.S. goods in world markets.

Since 1981, we have been supporting groups working on this problem through both competitive national programs and individual grants. Over $74 million, or roughly 36 percent, of our awards since that time have addressed the issue of costs. Major programs have been launched that are designed to reduce costs by cooperative community efforts or by prepaying for medical care. Physician-directed efforts at cost containment and programs to improve hospital payment mechanisms, to find better ways to finance long-term care, and to better manage patients with disabling chronic illnesses less expensively have also received Foundation support.

Because government, business, and many others have dramatically increased their efforts to reduce health care spending during this same period, we hope to increasingly focus our dollars on ideas and projects that fall outside the traditional scope of government or business support. But my central message is that progress has been made. It encourages me to believe that if enough public and private groups continue their work in this area, the nation's health care spending can be brought under better control without doing violence to the gains we have achieved during the last two decades.

**Problems in the health and medical care of the very young and very old**

This year we have placed more emphasis on programs directed at the health problems of the very young and very old. This stems from our conviction that much of our future national vitality depends on how effectively we as a people cope with the health and medical problems faced by those at each extreme of life's spectrum. Nearly one-half of all of the deaths in the United States each year occur in those under the age of one or over the age of 75. Ignoring the problems of either of these two age-separated segments of our society puts at peril the other.

Let me give you a few facts on which I base that statement. First, our splendid successes in making entry into this world progressively less hazardous are well known. One hundred years ago infant mortality rates were 170 per 1,000. As shown in Figure 2, just since 1920, infant mortality rates have dropped from 85.8 per 1,000 to 10.9 in 1983, a level thought almost unobtainable only a decade ago. We have made enormous and satisfying progress in improving the life chances of children born in this country.

But this has had a secondary, quite logical effect which brings with it yet new problems. As infant mortality rates have dropped profoundly, so have birth rates and family size. And herein lies our dilemma. When this lowered birth rate is coupled with our equally dramatic successes in maintaining life
at the other end of the age spectrum, one sees emerging a future American population that grows steadily older during the coming decades. Thus, moving into the 21st century, our country will have a demography totally different from anything the world has ever known. It will have many more oldsters and proportionately many fewer young people.\(^5\)

Let me punch home my point with a few statistics. In Roman times, the average life expectancy was about 25 years.\(^6\) In 17th century Europe, it was 30.\(^7\) In the United States, life expectancy was 49\(^8\) in 1900, while today, it is almost 75 years.\(^9\) We are certainly moving toward a very different world, one in which a progressively shrinking number of young people are going to be surrounded by an increasing number of old folk who have preceded them.

Few realize that since 1960 the elderly have fared better than children in terms of public expenditures. The reasons for this are many. They include, among others, the decrease in the number of children (down 7 percent between 1960 and 1982) and the sharp rise in those over 65 (up 54 percent between 1960 and 1980). It also stems from cutbacks in public programs for children while expanding those for older people, and the huge sums now spent on medical care during the last months of life for older citizens.\(^10\)

These demographic changes need our close attention. For if we couple these facts together—a decreasing number of births, an increasing number of aged, and the knowledge that our sophisticated world of tomorrow will require the brightest and most able of young people to master and control it—the reasons for focusing on the very young and very old become obvious. It is absolutely critical to all of us that each child born alive in our society today and tomorrow have the maximum chances of being physically, mentally, and socially healthy. If our world is to function successfully in that future, our young people must become highly effective and productive citizens. Similarly, with more people attaining longer lives, our elderly must be helped to better maintain their independence and vitality than is the case today.

### Improving the survival and health of newly born infants

Since the Foundation’s arrival on the national scene, we have been concerned with the health of children. Our programs in this area have been many and varied, and have spanned the full age spectrum of young people. These broad efforts continue. Our present attention to newborn infants stems from the following: although many would argue that our record is unfairly measured against countries with smaller, more homogeneous populations, the fact remains that the United States continues to stand poorly on the world’s infant mortality scorecard. This looms in importance when one realizes that deaths in infancy remain far and away the biggest contributor to childhood deaths in this country. Let me give you another statistic I find startling: of 100 children destined to die before the age of 20, 55 of them will die before they reach 1 year of age.\(^11\)

What is the problem here? Again, we are victims of our own successes. Of these early deaths, three-fourths will occur in babies of low birthweight.
Thus, in part, because of the marked overall improvement in the life chances for babies, the problem of low birthweight has emerged as the single most important cause of death or subsequent handicaps in infancy. Although low birthweight babies (below 5.5 pounds) represent only 7 percent of all babies born, well over half of all infant deaths occur among this group.12

Low birthweight babies also have many more illnesses and are much more at hazard of having serious difficulties when of school age than their normal weight counterparts. The problem is even more serious for very tiny infants. The 1 percent of babies whose birthweights are very low — below 3.3 pounds — are 200 times more likely to die in the first few weeks of life, and 3 times more likely to suffer from congenital anomalies or developmental delay if they do survive.13

We have known these relationships for many years, but we have not yet been able to dramatically reduce the number of low birthweight babies who enter the world. Our medical advances to date have been in our abilities to keep tiny newborn babies alive. The development of regional systems of care for mothers and the management of tiny newborns in special neonatal intensive care units have done much to improve infant survival. But as shown in Figure 3, despite the dramatic overall changes in infant mortality, the incidence of low birthweight babies born in this country has declined only slightly in the past few years.

Figure 3

Infant mortality and low birthweight rates, 1970-1983
Today, there is a growing awareness that if we are to reach that goal that I mentioned—namely, that all surviving infants are healthy and capable of growing into responsible and productive adults—we must know more about the physiologic reasons for and develop better methods to reduce the number of infants born too small to function adequately.

For some years our foundation has invested heavily in the area of infant health. Since we began focusing on this issue, approximately $47 million of our grant funds have been aimed at improving infant survival and caring for low birthweight infants. We will continue to encourage improving access to state-of-the-art medical care for all children. However, during the next few years we will look with interest at programs designed to identify the conditions that increase the risk of having a low birthweight infant, programs seeking to reduce this risk, and research on new approaches to prevent premature labor and promote the normal growth and development of unborn infants.

**Improving the quality of life for the elderly**

And what is happening in the lives of the aged—the other end of life’s spectrum? During the past 15 years, the United States has made dramatic improvements in life expectancy, and for most this has meant additional, fruitful years of life after retirement and opportunities to try new and different pursuits. Contrary to popular belief, most Americans over the age of 65 are not in poor health. According to recent statistics two out of three elderly Americans describe themselves as being in good or excellent health, and not seriously limited by major medical disabilities.\(^{14}\)

But there is the other side of this coin. For about one out of five individuals over the age of 65, poor health is a major problem that commonly limits their ability to live independently.\(^ {15}\) It is chronic illness or disability, not death, that is now the nemesis of the old.

For most Americans, the chances of disability rise sharply after the age of 75. Almost one-half of the people over the age of 75, as shown in Figure 4, are limited in activities important to their daily living. As a result, many need assistance with personal care like bathing, or dressing, or eating, or using the toilet. The social significance of these facts lies in another fact: today, those 75 and over constitute the fastest growing segment of our society. Indeed, during the 1970s the number of elderly in the United States increased at a faster rate than the population of India!\(^ {16}\) Those over 75 now number 11 million. By the year 2000, they are expected to number 17 million—with more than 100,000 Americans over the age of 100.\(^ {17}\)

But even today, the costs and burdens of the medical problems of old folk weigh disproportionately upon both the elderly and upon the rest of society. Nearly one-half of all patients in acute general hospitals, and over 70 percent of all patients in nursing homes, are over age 75. Unless we are able to improve our methods for medical management of the problems of our frail elderly to allow more of them to live independently, forecasts suggest that this country will move from 1 million people 75 years of age and older...
currently residing in nursing homes, to upwards of 5 million by the year 2040. We should be able to do better than this.

Many are also concerned about two additional problems. One is the growing use of medical technologies to sustain life of an unacceptable quality for many of our elderly. The other is the quantity of medical resources expended upon them at the end of life (Figure 5). Alas, all too often it would appear that these expenses are incurred for highly invasive, sometimes painful, and sometimes perhaps inappropriate medical care efforts that elderly patients and their relatives might not sanction if they fully understood the situation. These problems also need more national attention and more imaginative, enlightened, and less costly solutions. For the first time in world history, old people are surviving in sufficient numbers to become not only a medical, but a social, economic, and political reality affecting the lives of all of us. How to make life better and more fulfilling for a growing, dependent, vulnerable, disabled, and aged population, especially for those over 75, has become one of our most important unsolved national dilemmas.

We have focused a substantial share of our resources on improving the lot of older people. Most of our funds have been targeted on programs seeking new ways to help fragile elderly patients remain outside hospitals or nursing homes and to improve the ability of these individuals to care for themselves. We have been impressed with how simple and how inexpensive some highly successful programs have been. We will continue work in this area.

**Figure 5**

Percent of Medicare expenses in the last year of life, 1976

![Bar graph showing percent of Medicare expenses in the last year of life](image-url)
Continuing work on improving access to medical care for those most seriously underserved

Those who have followed our programs know that improving access to medical services for people having serious difficulties obtaining care has been a major focus of this foundation since it emerged on the national scene in 1972. Between 1972 and 1980, fully 76 percent of our funds were devoted to this purpose, including studies to pinpoint which groups or segments of our society were having the most difficulties in obtaining necessary medical care. Between 1981 and 1984, with the change in our program thrust, we have expended $74 million, or about 36 percent of our funding, in this traditional area of concern.

Since 1972, impressive strides have brought many previously underserved Americans into the medical care system. Increasing numbers of well-trained physicians, increasing coverage by private and public health insurance, and the availability of publicly-provided health services in many parts of the country have been responsible for a marked decline in the number of Americans unable to obtain appropriate medical care.

However, the rapid changes that are now occurring in the health care system—including changes in the ways hospitals are being reimbursed and the consequences of tough economic times—have led many to worry about whether those gains are being sustained. Thus, some of our recent grants have gone to groups trying to keep track of how well our system of medical care is serving us all. Other grants have supported institutions and groups targeting their efforts on improving access to medical care for those who remain underserved.

A study completed last year suggested that about 12 percent or 28 million Americans were continuing to have difficulty obtaining medical care. This figure did not include the estimated 250,000 to 2-million-plus adults and children who are homeless and thereby uncounted in most major national studies. This study also showed that while being poor created problems in access, being without health insurance or losing it was an even more serious obstacle to obtaining care. As shown in Figure 6, those who were without health insurance were almost three times as likely to feel they were unable to obtain needed health services or that they had been denied health care for financial reasons. The same applied for children. As shown in Figure 7, while being poor or nonwhite increased a youngster’s chance of not having a regular source of care, being uninsured had even more significance.

Knowing that lack of insurance makes one more likely to lose medical care sources and that the number of Americans without health insurance was growing has led us to try to determine what is happening to their medical care. Evidence is difficult to come by, but there are a few straws in the wind. For example: between 1980 and 1982 there was a 21 percent increase in the number of low-income Americans without health insurance. However, during this same period the nation’s community hospitals, the traditional care institutions of last resort for low-income people, were only able to increase their provision of uncompensated medical care by less than
Figure 6
Indicators of barriers to access to health care, 1982

- People with no regular source of care: 10.8%
  - Percent of total U.S. population: 11.9%
  - Percent of poor population: 23.1%

- Families who did not obtain needed health care in past year: 5.6%
  - Percent of total U.S. population: 8.9%
  - Percent of poor population: 15.0%

- Families who were refused care for financial reasons: 1.5%
  - Percent of total U.S. population: 2.8%
  - Percent of uninsured population: 3.6%

Figure 7
Characteristics of children under 17 who do not have a regular source of health care, 1982

- Percent without a regular source of care
  - All U.S. children: 5.8%
  - White: 4.8%
  - Nonwhite: 11.0%
  - Family income:
    - $15,000 or less: 9.1%
    - More than $15,000: 4.2%
  - With health insurance: 5.0%
  - Without health insurance: 14.6%
4 percent (Figure 8). This is by no means conclusive, but it does suggest that during this period more people may have had trouble getting care.

But clearly, the bottom line question is: "Does loss of medical care services actually make a difference in one's health?" Common sense says yes, but objective, quantifiable evidence is sparse. The few recent studies that have attempted to examine this problem, however, seem to come to the same conclusion. Statistics suggest that while infant mortality rates are going down in 55 of 81 cities for which such data are available, they appear to be rising in 23.20 A California study that followed a Medicaid population with high blood pressure found that those who lost their Medicaid insurance and with it, continuing physician care, had a significant rise in blood pressure and more deaths than did a similar group who had not lost their medical care services.21 Taken together, these preliminary reports are worrisome. The nation's medical coverage of vulnerable groups may be slipping.

Thus, the Foundation will continue to work on a variety of programs seeking to continue medical care services for all those who need them. The Foundation will look with interest at groups, or physicians, or hospitals, or institutions around the country that need assistance in developing or evaluating programs by which voluntary, state, or local governmental groups create new financing mechanisms to help pay for the care for those who now have difficulty getting it. We will also continue to assist those concerned with monitoring the success of such efforts.

Likewise, the Foundation will be looking beyond stopgap measures for imaginative ways to help health care institutions continuing to offer considerable care to the less fortunate. Institutional efforts to try to provide these services more effectively, or restructuring to help improve their financial viability while they maintain their services to the people without means, will receive attention. The Foundation, on a selective basis, will also continue its role of supporting studies to determine the extent and nature of the access to care problem.

The growing challenge of transmedical problems
Since we began our work in health on the national scene in 1972, we have known that "health" or "medical" problems cannot always be neatly dissected away from a myriad of other problems—social, psychologic, or economic—that generally beset those in trouble.

Our work with many groups during the past several years has made us yet more vividly aware of this fact. Human misery is generally the result of, or accompanied by, a great untidy basketful of intertwined and interconnected circumstances and happenings. Often all need attention if the problem is to be overcome. We have found, however, that approaching a seemingly insoluble or multifaceted problem via the "health" route is often a way to start progress. Health care, and those who deliver it, are generally regarded as nonjudgmental and politically neutral. People will often open their doors and share their problems with a doctor or a nurse much more readily than with others in our society. In this way, the organization of medical care
services can serve as a magnet attracting other human support services so necessary for real programmatic success.

Thus, we will continue to approach tough, multifaceted problem areas of human concern via the "health" route. This is our area of expertise. However, in so doing, we will continue to look with favor on efforts of our grantees to link other support services to the delivery of medical care where such are needed for more satisfactory progress. In this way, we hope that many of our grantees will continue to be catalytic institutions for improvements in American life.

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Figure 1.


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The 1984 grant program
The 1984 grant program

During 1984 the Foundation made 198 grants totaling $59.4 million in support of programs and projects to improve health care in the United States. The types of activity supported were:

- developing and testing new ways of providing health care services, $42.6 million, or 72 percent of the 1984 grant funds;
- helping health professionals acquire new skills needed to make health care more accessible, affordable, and effective, $8.2 million, or 14 percent;
- conducting studies and evaluations to improve health care, $7.3 million, or 12 percent; and
- other projects, $1.3 million, or 2 percent.

These same grant funds, viewed in terms of the Foundation’s principal objectives, were distributed as follows:

- $17.9 million, or 30 percent, for programs to improve access to personal health care for the most underserved population groups;
- $25.1 million, or 42 percent, for programs to make health care arrangements more effective and care more affordable;
- $13.5 million, or 23 percent, for programs to help people maintain or regain maximum attainable function in their everyday lives; and
- $2.9 million, or 5 percent, for a variety of other purposes, principally in the New Brunswick, New Jersey area where the Foundation originated.

Appropriations totaling $206.5 million have been made since 1981 when the Foundation changed its principal areas of interest to those stated above. The distribution of these funds by types of activities supported as well as by areas of interest is charted on the facing page. Since becoming a national philanthropy in 1972, our appropriations have totaled $584.9 million, and a chart depicting the geographic distribution of these funds is on page 26.
Appropriations by RWJF objectives and types of activities funded, 1981-1984

RWJF 4-year appropriations: $206.5 million
 Appropriations by geographical region compared to population, 1972-1984

MAJOR DEVELOPMENTS IN THE 1984 GRANT PROGRAM

The grant-supported projects and programs described in the first part of this section were selected to illustrate the Foundation’s 1984 grant program. A complete list of grants made in this year begins on page 37.

In addition to the activities funded during 1984, staff of the Foundation continued to monitor and provide technical assistance to projects and programs supported by 493 grants authorized in previous years.

Also involved in this process were 18 senior program consultants and their staffs at medical schools, teaching hospitals, and other institutions providing technical assistance and direction for the Foundation’s multi-grant national programs.

REDUCING COST INCREASES

Increasing health care costs, far exceeding the rates of inflation, continue to trouble this nation. While some cost-containment efforts have had limited success in slowing this increase, long-term answers remain elusive.

One of the imperatives of this decade is to find solutions that can wrest us from this financial spiral without compromising access to, or the quality of, medical care. With Foundation support, a growing number of people and institutions across the country are committing to that effort.

Prepaid managed care

Thirteen health care organizations receiving grants under the Foundation’s Program for Prepaid Managed Care are demonstrating one approach intended to contain medical costs while sustaining accessible and quality health care, particularly for the poor served under federal-state Medicaid programs. Primary care physicians in the participating institutions serve as gatekeepers for medical and hospital services for an enrolled group of at least 15,000 patients. The physicians or their institutions, working with state and federal agencies and private health insurers, are paid a fixed amount per person, regardless of the number or kinds of services that are provided. The Program is co-sponsored by the federal government’s Health Care Financing Administration and the National Governors’ Association.

Community programs

In the Foundation’s Community Programs for Affordable Health Care, grants were made to groups in Worcester (Massachusetts), Pittsburgh, Detroit, and New York City to implement projects designed to slow the rate of increase in local health care costs. Up to eight more communities will ultimately receive implementation grants under this program. The projects are based on the combined efforts of representatives of hospitals, health insurers, business, labor, and other groups using a variety of cost-containment strategies. The Foundation’s grants, of up to $1.5 million each, are matched with local funds equaling at least one-third of the total project costs. The Program is co-sponsored by the Blue Cross and Blue Shield Association and the American Hospital Association.

R & D on health costs

The Foundation also received and reviewed over 140 proposals under the Program for Research and Development on Health Care Costs. The Program annually offers three-year support for projects implementing or evaluating cost-saving strategies in the organization, financing, and delivery of health care. Grants in this the second round will be made in early 1985.

Strategies for hospitals

For several years, hospital costs have been increasing at rates two to three times the
Consumer Price Index. Inflation, accelerating health sector wages, and advancing technology are boosting the cost of services and compelling hospitals to take a new look at how to preserve their quality of care while restraining costs. One such program, at the New England Medical Center (NEMC), is decentralizing management so that the professionals prescribing and providing services, procedures, tests, and medications share in cost-accountability for their decisions. This is being done in each clinical department through a leadership team composed of a physician, nurse, and administrator that is responsible for determining protocols, staffing, and expenditures.

InterStudy is a Minneapolis-based research and consulting organization seeking to improve the delivery and financing of health services. One of its concepts, the Medical Staff-Hospital Joint Venture (MeSH), joins hospitals and private physicians together in cost-saving joint ventures for the delivery of health care. This may involve establishing HMOs or preferred provider organizations (PPOs), or negotiating with Medicare, Medicaid, private insurers, and private corporations for innovative packages of care. A grant this year is enabling InterStudy to help five hospitals set up projects using the MeSH arrangement.

One area frequently targeted for hospital cost reduction measures is that of ancillary
services—laboratory tests and radiological procedures. A grant to The University of Pennsylvania School of Medicine is supporting a study to identify the ancillary services that have increased the most, the cost implications of these services, and the varying patterns of their use by type of hospital and region of the country.

The National Executive Service Corps, with renewed grant support, is expanding its hospital management demonstration program. Under this program, retired senior executives from business are placed as consultants to assist hospitals in improving their management and governance.

**Long-term care services**

The growing numbers of elderly people in this country are increasing the need for long-term care services. The ACCESS project, under the auspices of the Monroe County Long Term Care Program in Rochester, New York, uses centralized, case-management for such community services. With this year’s grant, however, researchers in the ACCESS project are continuing a randomized controlled study to evaluate whether this approach or neighborhood-based, decentralized case management—with limited caseload size and the substitution of informal unpaid services by family and friends—is more cost-effective in caring for the frail elderly.

Finally, with our support and additional funding from five other foundations, The Brookings Institution is conducting a national study to examine the options available for improving the financing and organization of long-term care for health-impaired elderly individuals. Guided by an advisory committee from the fields of health care, insurance, government, voluntary service, and public policy research, the study team will examine issues relating to current and future needs for long-term care services and the benefits of various strategies for improving the financing of services.

**IMPROVING FUNCTIONAL STATUS**

Medical care is sometimes seen as being limited to simply treating the biologic and physiologic problems created by disease. There is, however, another aspect to medical care: ensuring that people retain or resume maximal function allowing them to perform the ordinary tasks of daily living. This year in programs emphasizing this aspect of health care, we gave particular attention to infants threatened by disabling conditions because they were born too early or too small, and to those elderly individuals imperiled by, or at risk of developing, chronic health problems.

**For infants**

Approximately 240,000 low birthweight infants are born each year in this country. Because of their size—less than 2,500 grams or 5.5 pounds—they are at increased risk for developmental and neurological problems. This year, eight teaching hospitals and academic health centers received grants under the Infant Health and Development Program to participate in a three-year national collaborative study testing the efficacy of combining comprehensive pediatric care with developmental and educational services for the prevention of health and learning problems among low birthweight infants. The Program—the largest scientific study in this field to date—is directed from Stanford University with assistance in program development from the Frank Porter Graham Child Development Center in Chapel Hill, North Carolina.

The long-term health outcomes of high-risk infants—those infants who have survived major medical problems in the neonatal period—is under special study at The Children's Hospital of Philadelphia. The health and developmental status of these children will be assessed at preschool and early elementary school ages. The study is also examining the impact that a child born at a low birthweight may have on a family over time, and is comparing the use of health, education, and
social services by very low birthweight children (less than 1,500 grams or 3.3 pounds) with those of normal birthweight.

Irrespective of birthweight, newborn infants that require treatment in neonatal intensive care units also appear to be at risk for neurodevelopmental difficulties. With previous support from the Foundation, the University of Iowa College of Medicine has established a statewide program for such children that involves assessments and medical referrals at ages 4, 9, 18, and 30 months. Our grant this year, with additional funding from the state of Iowa, the Iowa Crippled Children’s Program, and three hospitals, is enabling the program to be extended to include a child’s fifth year.

**For elderly individuals**

Twenty-five ecumenical coalitions of over 600 churches and synagogues in 17 states, the District of Columbia, and Guam—comprising such diverse groups as Christian, Jewish, Muslim, Bahai, and Buddhist congregations—have joined together and are reaching out to help isolated elderly and disabled people to continue living in their own homes. With grants announced this year, the Interfaith Volunteer Caregivers Program supports these coalitions in enlisting and training volunteers to locate those who need help and make sure that the mix of home health care, respite care, benefit programs, and other services essential to independent living are obtained. The Program is co-sponsored by the National Interfaith Coalition on Aging.

Ohio Presbyterian Homes, an interdenominational system of seven retirement communities, is using our funds to develop an outreach program. Incorporating the resources in the seven communities, and drawing upon a cadre of volunteers, the program has been designed to organize, coordinate, and provide in-home, long-term care services for frail elderly people living in nearby communities.

In the Foundation’s Rural Hospital Program of Extended-Care Services, 26 rural hospitals are providing long-term care services using the “swing-bed” concept. This concept uses certain hospital beds for either acute or long-term patients depending upon needs. The Program is overcoming local shortages of nursing home beds and enabling rural residents to remain in their communities for long-term care. The University of Colorado Center for Health Services Research, with a grant approved this year, is joining with the federal Health Care Financing Administration to evaluate the effectiveness of the Foundation’s program and to determine how well patients fare in hospital swing-beds as compared to traditional nursing homes.

Two other grants this year are helping to underwrite studies of innovative approaches to health care for elderly people. In one, a team of investigators at the University of Oregon’s Center for Gerontology, in cooperation with the state’s Senior Services Division, is studying the impact of a number of the state’s legislative and administrative actions redesigning long-term care programs and identifying alternatives to nursing home care.

The other is a study of the Mountain States Health Corporation’s geriatric nurse practitioner project. A persistent problem for elderly individuals in nursing homes has been the dearth of staff able to provide basic primary care, and hospitalization often occurs for even minor ailments. A $5-million, 11-state program, originally funded by the W.K. Kellogg Foundation, addressed this problem by placing the geriatric nurse practitioners in nursing homes to provide primary care. Our funds are being used by the Rand Corporation to examine the quality of care in this arrangement, together with its cost implications.

**For young people**

Teenage pregnancy continues to be an alarming problem. Today, well over a million U.S. teenagers become pregnant annually, and more than half of them bear children. With Foundation support, two programs are
focusing on this problem of children bearing children. A supplemental grant to The University of Pennsylvania School of Nursing is continuing a program geared to returning teenage mothers to school, helping them prevent subsequent pregnancies, and improving the health of their babies. In the other program, the National Research Council of the National Academy of Sciences, with additional funding from the Ford, Hewlett, and Rockefeller Foundations, is convening a panel of experts to conduct a comprehensive evaluation and report on a variety of public and private efforts to reduce teenage pregnancy and related health and social problems.

Between 1.2 and 3.8 million American children are chronically ill and unable to carry out even the most routine daily activities. For them, assistance is essential for bathing, dressing, eating, and other tasks most of us take for granted. To help these children and their families, The National Council on the Aging is collaborating with the Hospital for Sick Children and Children’s Hospital National Medical Center in Washington, D.C., to develop, implement, and evaluate a model program enlisting senior citizens as volunteers trained to provide a variety of home services to chronically ill children and their families.

**For others at risk**

Staff at Memorial Sloan-Kettering Cancer Center and Brown University are continuing to evaluate an adult day hospital in which selected cancer patients receive their care as outpatients rather than inpatients. The study is assessing the physiologic, psychosocial, and cost implications of this new approach to cancer treatment.

Another grant—to Cornell University Medical College—is supporting the continuation of work to improve physicians’ ability to make early determinations of the potential outcomes for patients with strokes. Investigators in the project are now able to classify patients according to their eventual capabilities to resume normal activities and return to work. This information is vital in selecting strategies of care most appropriate to the current and projected needs of individual stroke patients.

**Exploring new approaches**

This year, 197 requests for support were received and reviewed under the Foundation’s Research and Development Program to Improve Patient Functional Status. Now in its fourth round, the Program provides support ranging from one to three years to approximately 20 projects demonstrating or evaluating interventions that prevent or alleviate disability and restore function. Grants will be made in early 1985.

**ACCESS TO CARE**

From the outset, one of the Foundation’s primary objectives has been to improve access to health care for underserved groups in this country. This year we continued to target efforts on those who are among the most vulnerable.

**In our cities**

Coalitions of public and private agencies in 18 of the country’s largest cities received grants this year under the Health Care for the Homeless Program, which we co-funded with The Pew Memorial Trust. The people served under this program are a diverse population. They include alcohol and drug abusers, runaway children, deinstitutionalized mental patients, and individuals and even whole families that become homeless because of unemployment, lack of affordable housing, or family or life crises. Their health problems, often severe and potentially fatal, are rooted in the circumstances of their lives. For this reason, the Program is designed around a “transmedical” strategy addressing more than the immediate medical needs of the homeless. Grant funds are limited to health care activities, but the coalitions must also provide
for a full range of health, social, and other services, including food, shelter, and assistance for drug and alcohol problems. The Program is co-sponsored by the U.S. Conference of Mayors, with technical assistance and direction provided by St. Vincent’s Hospital and Medical Center of New York.

In another project focusing on urban health issues, the U.S. Conference of Mayors’ Research and Education Foundation and Georgetown University Center for Health Policy Studies are using our funds to implement a uniform system for tracking selected morbidity and mortality trends for the country’s 25 largest metropolitan areas. This information system is intended to help public officials identify problems and make better informed decisions on health funding at local, state, and national levels.

The University of Chicago is using another of our grants to take a new look at how underserved groups in urban areas get their health care. In recent years, a major approach
to improving access to medical care has been to expand hospital outpatient clinics and neighborhood health centers, especially in inner cities where physicians have historically been in short supply. This latest study is examining whether the increasing numbers of physicians entering practice in recent years have reduced these shortages and changed how people in these communities receive care.

For people with chronic disorders
Providing dental care to developmentally disabled people has traditionally been impeded by the low fees paid by Medicaid, recent cutbacks in Medicaid coverage for dental services, and the limited number of states offering any dental coverage. In an attempt to develop a more cost-effective approach to meeting the dental needs of people who are developmentally disabled, the National Foundation for Dentistry for the Handicapped is using our funds to test a prepaid dental program as an alternative to Medicaid's fee-for-service arrangement for this target population.

Also with continued support this year, the New Jersey Hospital Association is implementing a statewide network of personal emergency response systems (PERS) electronically linking homebound people with a monitoring unit staffed around the clock, seven days a week. When an emergency occurs, a special device is used to signal the monitoring unit, which in turn notifies the nearest hospital participating in this system. It is anticipated that by the end of 1985 PERS will be available to the homebound in all of New Jersey's 21 counties.

For children in need
Continuation support to Harvard Medical School this year is assisting the Healthy Children project to encourage the development of model child care programs in communities where identifiable groups of children lack primary care and other health services. Pediatricians and others concerned with child health are encouraged to assess their communities' needs and then draw upon information materials and a network of experienced professionals available through the Harvard project in order to develop affordable, locally financed services.

Children with behavioral disorders or who have been labeled as chronic school failures often have subtle but debilitating neurodevelopmental problems not detected in the course of routine pediatric assessments. A grant to the University of Maryland School of Medicine is helping researchers test the Pediatric Early Elementary Examination (PEEX) with disadvantaged, inner-city children. PEEX is a sensitive neurodevelopmental assessment instrument which—if applicable to this population—can be used to assess a child's strengths as well as deficits. This is particularly crucial for children from low-income families—children who are often seen only in terms of their limitations. Children identified as having problems in the test will be referred to a cooperating school health program.

For others in need
Migrant workers and their families, poor and lacking health insurance and access to health services, typically go without care until a crisis occurs. Moreover, the hospitals, clinics, and physicians that do serve these families oftentimes bear a substantial financial burden in bad debts. The Center for Strategic Health Planning, an arm of the Central California Hospital Association, is using our grant to establish a prepaid, physician-managed health program for 5,000 migrant worker families. Payment is provided through the creation of a fund pooling whatever monies are available from government, the growers, and workers themselves, with Blue Cross of California underwriting and assuming full risk for the benefit package.

In 1981 the Arizona legislature authorized the state—then the only one in the nation not participating in Medicaid—to enter into an
agreement with the federal government to pay for health services for needy individuals. The new plan, called the Arizona Health Care Cost Containment System (AHCCCS), brought federal Medicaid funds to Arizona in the form of a three-year experiment using prepaid managed care networks to provide health care to indigent people. Prior to the inception of AHCCCS, the Foundation joined with the Flinn Foundation of Phoenix to sponsor a survey by Louis Harris and Associates on access to health care by the poor in Arizona. This year, a grant to Arizona State University’s College of Business Administration is assisting a follow-up survey to evaluate the AHCCCS program.

The Associated Clinics of Appalachia (ACA) is using our funds for a prepaid program seeking to reduce Medicaid expenditures in rural West Virginia without restricting access to care for poor individuals. ACA is not providing services directly but rather contracting with the state and with clinics and private physicians to bring health care to patients under Medicaid.

Sustaining community services
Since May 1981, the Foundation’s Community Care Funding Partners Program has been supporting centers tailored to bring front-line, affordable medical services to population groups identified as lacking adequate health care. In the Program, local foundations and corporations join with us in providing eight years of support for health services in underserved sections of their communities. This year two projects received assistance. The Cook Inlet Native Association in Alaska is establishing a primary care center for low-income elderly people. The other grant was awarded to the Flint (Michigan) Area Health Foundation, and is the second grant under the Program to this group. It is being matched locally to establish a health care center in the northwestern part of the city to serve an adolescent population at high risk for alcohol and drug abuse and teenage pregnancy. Thus far in the Community Care Funding Partners Program, nine projects in five communities have been assisted.

In recent years many primary care centers have been feeling the combined effects of increasing numbers of indigent patients and decreasing amounts of public assistance for their health care. The Foundation has responded by providing supplemental grants to centers established in underserved communities with Foundation support over the
last decade. The supplements are intended to give these centers additional time to gain more financial stability and compete for other public and private assistance. To qualify, each center must meet a set of specific criteria relating to present and future viability and the needs of the people they serve. In addition, they must receive a satisfactory on-site review by an independent management consulting firm. This year, four centers received grants under this program: two in Kentucky, one in Ohio, and one in the Bedford-Stuyvesant section of New York City.

PROFESSIONAL DEVELOPMENT

Eight Fellows were selected under the second round of the Minority Medical Faculty Development Program for support beginning in 1985. This program provides four-year postdoctoral research fellowships with outstanding biomedical mentors to young minority physicians committed to academic careers. The Program was designed to prepare faculty who can serve as role models for the succeeding generation of minority medical students and postdoctoral trainees.

Three other programs aimed at expanding opportunities for minority individuals in medicine were assisted this year. The Associated Medical Schools of New York, the National Fund for Medical Education, and Tulane Medical Center received grants to support educational and training programs.

The first five Fellows were selected under the Program for Faculty Fellowships in Health Care Finance. The purpose of the Program is to develop a cadre of university faculty with the specialized skills needed to teach and conduct research in the rapidly changing field of health care finance. Fellows undergo three months of study at The Johns Hopkins Medical Institutions followed by a nine-month placement in a public or private health care financing organization.

LOCAL GRANTS

Each year, selected projects are assisted in the New Brunswick, New Jersey area where the Foundation was established in 1936. This year a grant was made in support of the urban revitalization project spearheaded by New Brunswick Development Corporation, a coalition of community, business, and government leaders. Grants were also made to the United Way of Central Jersey and The Salvation Army.

FOR FURTHER INFORMATION

A brief, descriptive Program Summary is available without charge for each of our 1984 grants, as well as for those made in prior years. When possible, requests should include the title of the grant, the institutional recipient, and the grant ID number. This information on the 1984 grants is available from the listing beginning on the next page. Address requests to:

Communications Office
The Robert Wood Johnson Foundation
Post Office Box 2316
Princeton, New Jersey 08540
### Summary of grants authorized in the year ended December 31, 1984

<table>
<thead>
<tr>
<th>Organization</th>
<th>Location</th>
<th>Description</th>
<th>ID Number</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Association of Hospital Dentists</td>
<td>Chicago, Illinois</td>
<td>Establishing a national focus for hospital-based dentistry (for 4 years).</td>
<td>ID#9246</td>
<td>$350,000</td>
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<tr>
<td>American Red Cross—Essex Chapter</td>
<td>East Orange, New Jersey</td>
<td>Flood relief funds for residents of northern New Jersey (for 9 months).</td>
<td>ID#9579</td>
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<tr>
<td>Arizona State University, College of Business Administration</td>
<td>Tempe, Arizona</td>
<td>Study of access to medical care in Arizona (for 1 year).</td>
<td>ID#9251</td>
<td>159,195</td>
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<tr>
<td>Associated Clinics of Appalachia, Inc.</td>
<td>Charleston, West Virginia</td>
<td>Demonstration of prepaid managed health care in rural areas (for 26 months).</td>
<td>ID#9018</td>
<td>259,728</td>
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<tr>
<td>The Associated Medical Schools of New York</td>
<td>New York, New York</td>
<td>Program to increase minority enrollment in medicine (for 3 years).</td>
<td>ID#8811</td>
<td>567,199</td>
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<tr>
<td>Bedford-Stuyvesant Family Health Center, Inc.</td>
<td>Brooklyn, New York</td>
<td>Program to strengthen the Center’s capacity to provide health services (for 4 years).</td>
<td>ID#9119</td>
<td>432,262</td>
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<tr>
<td>The Brookings Institution</td>
<td>Washington, D.C.</td>
<td>Study of long-term care financing and organization (for 2 years).</td>
<td>ID#9413</td>
<td>250,000</td>
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<tr>
<td>University of California, Los Angeles, School of Dentistry</td>
<td>Los Angeles, California</td>
<td>Evaluation of the Hospital-Sponsored Ambulatory Dental Services Program (for 8 months).</td>
<td>ID#9578</td>
<td>46,618</td>
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<tr>
<td>The Center for the Study of Social Policy</td>
<td>Washington, D.C.</td>
<td>Study of long-range alternatives for providing care to the poor and disabled (for 2 years).</td>
<td>ID#9097</td>
<td>248,513</td>
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<td>Center for Strategic Health Planning</td>
<td>Modesto, California</td>
<td>Farmworker health insurance project (for 2 years).</td>
<td>ID#9467</td>
<td>250,000</td>
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<td>University of Chicago</td>
<td>Chicago, Illinois</td>
<td>Study of who uses OPDs, community clinics, and private practices (for 2 years).</td>
<td>ID#9474</td>
<td>215,401</td>
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<tr>
<td>Program</td>
<td>Description</td>
<td>1984 grants authorized</td>
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<td><strong>Clinical Nurse Scholars Program</strong></td>
<td>Postdoctoral fellowships of advanced in-hospital clinical practice and research (for 1 year). ID#7514</td>
<td>$ 264,113</td>
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<tr>
<td>University of California, San Francisco, School of Nursing</td>
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<tr>
<td>San Francisco, California</td>
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<tr>
<td>The University of Pennsylvania, School of Nursing</td>
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<td>275,626</td>
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<td>Philadelphia, Pennsylvania</td>
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<td>University of Rochester, School of Nursing</td>
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<td>266,959</td>
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<td>Rochester, New York</td>
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<tr>
<td><strong>Clinical Scholars Program</strong></td>
<td>Postdoctoral fellowships for young physicians to develop research skills in non-biological disciplines relevant to medical care (for 2 years). ID#5109</td>
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<td>University of North Carolina at Chapel Hill, School of Medicine</td>
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<td>71,091</td>
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<td>Chapel Hill, North Carolina</td>
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<td>The University of Pennsylvania, School of Medicine</td>
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<td>90,706</td>
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<td>Philadelphia, Pennsylvania</td>
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<td>University of Colorado Center for Health Services Research</td>
<td>Evaluation of the Rural Hospital Program of Extended-Care Services (for 34 months). ID#6741</td>
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<td>Denver, Colorado</td>
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<td><strong>Community Care Funding Partners Program</strong></td>
<td>Primary care projects for underserved groups, jointly funded with local foundations and other private sources (for 5 years). ID#6397</td>
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<td>Cook Inlet Native Association</td>
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<td>Anchorage, Alaska</td>
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<td>Flint Area Health Foundation</td>
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<td>350,668</td>
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<td>Flint, Michigan</td>
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<td><strong>Community Programs for Affordable Health Care</strong></td>
<td>Planning or implementation of local projects to slow the rate of health care cost increases (for the periods indicated). ID#6748</td>
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<td>Allegheny Conference on Community Development</td>
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<tr>
<td>Pittsburgh, Pennsylvania</td>
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<td>(2 years)</td>
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<td>Arizona Community Foundation, Inc.</td>
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<td>Phoenix, Arizona</td>
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<tr>
<td>(1.5 years)</td>
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<tr>
<td>Organization</td>
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<td>Duration</td>
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<td>Clark University, Graduate School of Management</td>
<td>Worcester, Massachusetts</td>
<td>2 years</td>
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<td>Greater Boston Forum for Health Action, Inc.</td>
<td>Boston, Massachusetts</td>
<td>1 year</td>
<td>100,000</td>
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<td>Greater Detroit Area Health Council, Inc.</td>
<td>Detroit, Michigan</td>
<td>2 years</td>
<td>1,103,449</td>
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<td>The Health Services Improvement Fund, Inc.</td>
<td>New York, New York</td>
<td>2 years</td>
<td>1,194,608</td>
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<td>The Jane C. Stormont Hospital and Training School for Nurses</td>
<td>Topeka, Kansas</td>
<td>1.5 years</td>
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<td>Tulsa Business Health Group, Inc.</td>
<td>Tulsa, Oklahoma</td>
<td>1.5 years</td>
<td>100,000</td>
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<td>Conference of Mayors Research and Education Foundation</td>
<td>Washington, D.C.</td>
<td>Development of a uniform system to track health trends in cities (for 1 year). ID#9530</td>
<td>188,022</td>
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<td>Cornell University Medical College</td>
<td>New York, New York</td>
<td>Technical assistance and direction for the General Pediatrics Academic Development Program (for 1 year). ID#8760</td>
<td>87,838</td>
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<tr>
<td>University of California, Los Angeles, School of Dentistry</td>
<td>Los Angeles, California</td>
<td>Improving prognostic ability of physicians for patients with stroke (for 3 years). ID#9373</td>
<td>300,000</td>
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<td>Dental Services Research Scholars Program</td>
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<td>Dental faculty fellowships in health services research (for 2 years). ID#6720</td>
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<td>Beth Israel Medical Center</td>
<td>New York, New York</td>
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<td>University of California, Los Angeles, School of Dentistry</td>
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<td>193,955</td>
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<td>Columbia University, School of Dental and Oral Surgery</td>
<td>New York, New York</td>
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<td>101,000</td>
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<td>Harvard University, School of Dental Medicine</td>
<td>Boston, Massachusetts</td>
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<td>120,044</td>
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<tr>
<td>Institution</td>
<td>Location</td>
<td>1984 Grants Authorized</td>
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<tr>
<td>----------------------------------------------------------------------------</td>
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<tr>
<td>University of Iowa, College of Dentistry</td>
<td>Iowa City, Iowa</td>
<td>$ 96,000</td>
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<td>Montefiore Medical Center</td>
<td>Bronx, New York</td>
<td>100,000</td>
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<tr>
<td>Washington University, School of Dental Medicine</td>
<td>St. Louis, Missouri</td>
<td>67,280</td>
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<tr>
<td>East Kentucky Health Services Center, Inc.</td>
<td>Hindman, Kentucky</td>
<td>Program to strengthen the Center’s capacity to provide health services (for 4 years). ID#9120 355,292</td>
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<tr>
<td>Educational Testing Service — Education Policy Research Institute</td>
<td>Washington, D.C.</td>
<td>Study of programs to increase medical school minority enrollment (for 16 months). ID#9123 435,781</td>
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<tr>
<td>Emory University, The Carter Center</td>
<td>Atlanta, Georgia</td>
<td>Study of ways to further improve health in the United States (for 1 year). ID#9023 250,000</td>
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<tr>
<td>Faculty Fellowships in Health Care Finance</td>
<td></td>
<td>Program of study and field experience in health care finance for university faculty from related specialties (for 1 year). ID#8584 47,098</td>
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<tr>
<td>Boston University, School of Management</td>
<td>Boston, Massachusetts</td>
<td>47,098</td>
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<td>Columbia University, School of International and Public Affairs</td>
<td>New York, New York</td>
<td>38,430</td>
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<tr>
<td>University of Illinois-Chicago, School of Urban Planning and Policy</td>
<td>Chicago, Illinois</td>
<td>38,297</td>
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<tr>
<td>University of Oregon Development Fund</td>
<td>Eugene, Oregon</td>
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<tr>
<td>Yale University, School of Medicine</td>
<td>New Haven, Connecticut</td>
<td>45,920</td>
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<tr>
<td>Family Practice Faculty Fellowship Program</td>
<td></td>
<td>Program to prepare physicians for academic careers in family practice (for the periods indicated). ID#3579 1,320,000</td>
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<tr>
<td>Case Western Reserve University, School of Medicine</td>
<td>Cleveland, Ohio</td>
<td>(3.5 years)</td>
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<tr>
<td>Institution</td>
<td>Location</td>
<td>Proposal Title</td>
<td>ID#</td>
<td>Amount</td>
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<tr>
<td>University of Missouri, Columbia, School of Medicine</td>
<td>Columbia, Missouri</td>
<td>Program to strengthen the capacity of the Service to provide health care (for 4 years).</td>
<td>9118</td>
<td>$1,319,883</td>
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<td>University of Washington, School of Medicine</td>
<td>Seattle, Washington</td>
<td>Analysis of health policy issues (for 1 year).</td>
<td>8893</td>
<td>220,623</td>
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<tr>
<td>Frontier Nursing Service, Inc.</td>
<td>Hyden, Kentucky</td>
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<td>Georgetown University, School of Medicine</td>
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<tr>
<td>Glenville Health Association</td>
<td>Cleveland, Ohio</td>
<td>Strengthening a health center’s capacity to provide essential medical services (for 4 years).</td>
<td>9105</td>
<td>300,000</td>
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<tr>
<td>Grantmakers in Health</td>
<td>New York, New York</td>
<td>Educational program in health philanthropy (for 3 years).</td>
<td>9616</td>
<td>150,000</td>
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<tr>
<td>Harvard University, Medical School</td>
<td>Boston, Massachusetts</td>
<td>Program to encourage the development of children’s health services (for 2 years).</td>
<td>8763</td>
<td>698,969</td>
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<tr>
<td>Health Care for the Homeless Program</td>
<td></td>
<td>Projects involving urban coalitions of public and private agencies in providing and coordinating health and other services to the homeless (for 2 years).</td>
<td>8637</td>
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<tr>
<td>Boston City Hospital</td>
<td>Boston, Massachusetts</td>
<td></td>
<td></td>
<td>650,499</td>
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<tr>
<td>University of California, Los Angeles, School of Nursing</td>
<td>Los Angeles, California</td>
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<td>681,720</td>
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<tr>
<td>Coalition for Community Health Care</td>
<td>Milwaukee, Wisconsin</td>
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<td>685,144</td>
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<tr>
<td>Colorado Coalition for the Homeless</td>
<td>Denver, Colorado</td>
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<tr>
<td>Community Foundation of Greater Washington</td>
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<td>749,905</td>
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<tr>
<td>Council of Community Services</td>
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<td>615,488</td>
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<tr>
<td>Federation for Community Planning</td>
<td>Cleveland, Ohio</td>
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<td>700,000</td>
</tr>
<tr>
<td>Organization</td>
<td>1984 grants authorized</td>
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<tr>
<td>Fremont Public Association</td>
<td>$754,422</td>
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<td></td>
<td></td>
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<tr>
<td>Seattle, Washington</td>
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</tr>
<tr>
<td>Health and Welfare Council of Central Maryland, Inc.</td>
<td>577,232</td>
<td></td>
<td></td>
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<tr>
<td>Baltimore, Maryland</td>
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<td></td>
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<tr>
<td>City of Phoenix, Human Resources Department</td>
<td>669,392</td>
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<td></td>
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<tr>
<td>Phoenix, Arizona</td>
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<tr>
<td>St. Joseph's Hospital and Health Care Foundation</td>
<td>562,792</td>
<td></td>
<td></td>
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<tr>
<td>Albuquerque, New Mexico</td>
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<td></td>
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<tr>
<td>Travelers &amp; Immigrants Aid of Chicago</td>
<td>694,563</td>
<td></td>
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<tr>
<td>Chicago, Illinois</td>
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<td></td>
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<tr>
<td>United Community Services of Metropolitan Detroit</td>
<td>656,708</td>
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<tr>
<td>Detroit, Michigan</td>
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**Health Policy Fellowships Program**

*One-year fellowships with federal government in Washington, D.C., for faculty from academic health science centers (for 1 year). ID#4888*

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<tr>
<th>Institution</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Columbia University, School of Nursing</td>
<td>48,542</td>
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<tr>
<td>New York, New York</td>
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<tr>
<td>University of Florida</td>
<td>49,256</td>
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<tr>
<td>Gainesville, Florida</td>
<td></td>
</tr>
<tr>
<td>George Washington University, School of Medicine</td>
<td>47,040</td>
</tr>
<tr>
<td>Washington, D.C.</td>
<td></td>
</tr>
<tr>
<td>Hahnemann University School of Medicine</td>
<td>45,363</td>
</tr>
<tr>
<td>Philadelphia, Pennsylvania</td>
<td></td>
</tr>
<tr>
<td>The Ohio State University Research Foundation</td>
<td>46,590</td>
</tr>
<tr>
<td>Columbus, Ohio</td>
<td></td>
</tr>
<tr>
<td>University of Washington, School of Public Health and Community Medicine</td>
<td>43,291</td>
</tr>
<tr>
<td>Seattle, Washington</td>
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</tr>
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</table>

**Human Dimensions in Medical Education**

*Training medical faculty in interpersonal skills (for 3 years). ID#9442*

<table>
<thead>
<tr>
<th>Institution</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>La Jolla, California</td>
<td>250,000</td>
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</table>

**University of Illinois-Chicago, College of Nursing**

*Technical assistance and direction for the Clinical Nurse Scholars Program (for 1 year). ID#8909*

<table>
<thead>
<tr>
<th>Institution</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Chicago, Illinois</td>
<td>170,611</td>
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### Infant Health and Development Program

**National collaborative study to test the efficacy of combining early childhood development services with pediatric care in reducing the incidence of health and developmental problems among low birthweight infants (for 2 years). ID#7891**

<table>
<thead>
<tr>
<th>Institution</th>
<th>Location</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albert Einstein College of Medicine of Yeshiva University</td>
<td>New York, New York</td>
<td>$817,262</td>
</tr>
<tr>
<td>University of Arkansas, College of Medicine</td>
<td>Little Rock, Arkansas</td>
<td>870,940</td>
</tr>
<tr>
<td>Children's Hospital Corporation</td>
<td>Boston, Massachusetts</td>
<td>865,720</td>
</tr>
<tr>
<td>Medical Associates Research and Education Foundation (The Children's Hospital of Philadelphia—University of Pennsylvania)</td>
<td>Philadelphia, Pennsylvania</td>
<td>876,310</td>
</tr>
<tr>
<td>University of Miami, School of Medicine</td>
<td>Miami, Florida</td>
<td>827,215</td>
</tr>
<tr>
<td>The University of Texas, Southwestern Medical School at Dallas</td>
<td>Dallas, Texas</td>
<td>852,158</td>
</tr>
<tr>
<td>University of Washington, School of Medicine</td>
<td>Seattle, Washington</td>
<td>785,358</td>
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<tr>
<td>Yale University, School of Medicine</td>
<td>New Haven, Connecticut</td>
<td>797,003</td>
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### Interfaith Volunteer Caregivers Program

**Ecumenical coalitions of volunteers in projects coordinating health and other services enabling elderly and other vulnerable individuals to continue living in the community (for 3 years). ID#7879**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Location</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akron Area Association of Churches</td>
<td>Akron, Ohio</td>
<td>$150,000</td>
</tr>
<tr>
<td>Back Bay Aging Concerns Committee—Young and Old United, Inc.</td>
<td>Boston, Massachusetts</td>
<td>150,000</td>
</tr>
<tr>
<td>Catholic Charities of the Diocese of Yakima</td>
<td>Yakima, Washington</td>
<td>147,166</td>
</tr>
<tr>
<td>Catholic Community Services—Seattle/King County</td>
<td>Seattle, Washington</td>
<td>150,000</td>
</tr>
<tr>
<td>Diocese of East Carolina—St. James' Episcopal Church</td>
<td>Belhaven, North Carolina</td>
<td>150,000</td>
</tr>
<tr>
<td>Name</td>
<td>Location</td>
<td>Amount</td>
</tr>
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</tr>
<tr>
<td>The Downtown Cooperative Ministry, Inc.</td>
<td>New Haven, Connecticut</td>
<td>$150,000</td>
</tr>
<tr>
<td>Eastern Oregon Community Development Council</td>
<td>La Grande, Oregon</td>
<td>150,000</td>
</tr>
<tr>
<td>Eastern Virginia Medical Authority</td>
<td>Norfolk, Virginia</td>
<td>150,000</td>
</tr>
<tr>
<td>First United Methodist Church</td>
<td>Lewiston, Idaho</td>
<td>150,000</td>
</tr>
<tr>
<td>Good Shepherd Lutheran Church</td>
<td>Albany, Oregon</td>
<td>149,754</td>
</tr>
<tr>
<td>Institute for Religion and Social Change</td>
<td>Honolulu, Hawaii</td>
<td>149,995</td>
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<tr>
<td>Interfaith Conference of Metropolitan Washington</td>
<td>Washington, D.C.</td>
<td>190,000</td>
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<tr>
<td>Interfaith Program for the Elderly, Inc.</td>
<td>Milwaukee, Wisconsin</td>
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<tr>
<td>Interfaith Service Bureau</td>
<td>Sacramento, California</td>
<td>149,551</td>
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<tr>
<td>Interfaith Volunteer Caregivers, Inc.</td>
<td>Agana, Guam</td>
<td>150,000</td>
</tr>
<tr>
<td>Mahoning Valley Association of Churches</td>
<td>Youngstown, Ohio</td>
<td>149,976</td>
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<tr>
<td>Metropolitan Inter-Faith Association</td>
<td>Memphis, Tennessee</td>
<td>150,000</td>
</tr>
<tr>
<td>New Hampshire Catholic Charities, Inc.</td>
<td>Manchester, New Hampshire</td>
<td>150,000</td>
</tr>
<tr>
<td>Pontiac Area Lighthouse, Inc.</td>
<td>Pontiac, Michigan</td>
<td>147,737</td>
</tr>
<tr>
<td>San Antonio Urban Council, Inc.</td>
<td>San Antonio, Texas</td>
<td>150,000</td>
</tr>
<tr>
<td>Service Center of Catholic Social Services</td>
<td>Mobile, Alabama</td>
<td>150,000</td>
</tr>
<tr>
<td>Sisters of St. Joseph of Carondelet—Sisters of St. Joseph in California</td>
<td>Oxnard, California</td>
<td>150,000</td>
</tr>
<tr>
<td>St. John's Baptist Church</td>
<td>New York, New York</td>
<td>150,000</td>
</tr>
<tr>
<td>Organization</td>
<td>Location</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>---------------------------------</td>
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</tr>
<tr>
<td>St. Stephen’s Episcopal Church, Inc.</td>
<td>Olean, New York</td>
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<tr>
<td>Triniteam, Inc.</td>
<td>Eau Claire, Wisconsin</td>
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</tr>
<tr>
<td>InterStudy</td>
<td>Excelsior, Minnesota</td>
<td>Medical staff-hospital joint venture cost reduction program (for 2 years).</td>
</tr>
<tr>
<td>University of Iowa, College of Medicine</td>
<td>Iowa City, Iowa</td>
<td>Follow-up care for newborns treated in intensive care units (for 3 years).</td>
</tr>
<tr>
<td>Kingston Hospital</td>
<td>Kingston, New York</td>
<td>Technical assistance and direction for the Program for the Health-Impaired</td>
</tr>
<tr>
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<td>Elderly and the Interfaith Volunteer Caregivers Program and for other</td>
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<td>consulting services (for 1 year).</td>
</tr>
<tr>
<td>University of Maryland, School of Medicine</td>
<td>Baltimore, Maryland</td>
<td>Usefulness of pediatric early elementary exam among disadvantaged children</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(for 2 years).</td>
</tr>
<tr>
<td>Medic Alert Foundation International</td>
<td>Turlock, California</td>
<td>Development of a standardized personal emergency medical information</td>
</tr>
<tr>
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<td>system (for 2 years).</td>
</tr>
<tr>
<td>Medical Associates Research and Education Foundation (The Children’s Hospital</td>
<td>Philadelphia, Pennsylvania</td>
<td>Study of long-term health outcomes of high-risk infants (for 4 years).</td>
</tr>
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<td>of Philadelphia — University of Pennsylvania</td>
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<tr>
<td>Meharry Medical College</td>
<td>Nashville, Tennessee</td>
<td>Technical assistance and direction for the Program to Consolidate Health</td>
</tr>
<tr>
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<td>Services for High-Risk Young People (for 1 year).</td>
</tr>
<tr>
<td>Memorial Sloan-Kettering Cancer Center</td>
<td>New York, New York</td>
<td>Evaluation of the efficacy of an adult day hospital for cancer patients (for</td>
</tr>
<tr>
<td></td>
<td></td>
<td>32 months).</td>
</tr>
<tr>
<td>Middlesex County College</td>
<td>Edison, New Jersey</td>
<td>Registered nurse refresher course (for 2 months).</td>
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<td>Middlesex County College Foundation, Inc.</td>
<td>Edison, New Jersey</td>
<td>Health sciences scholarship program (for 10 months).</td>
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<tr>
<td>Middlesex General-University Hospital</td>
<td>New Brunswick, New Jersey</td>
<td>Property acquisition. ID#8939 and ID#9728</td>
</tr>
<tr>
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<td>Description</td>
<td>Amount</td>
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<tr>
<td>Minority Medical Faculty Development Program</td>
<td>Four-year program to provide two-year, biomedical, postdoctoral research fellowships (for 2 years). ID# 7854</td>
<td>$120,000</td>
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<tr>
<td>Emory University, School of Medicine</td>
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<tr>
<td>Atlanta, Georgia</td>
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<tr>
<td>Monroe County Long Term Care Program, Inc.</td>
<td>Evaluation of alternatives in the management of care for the elderly (for 1.5 years). ID# 9500</td>
<td>405,988</td>
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<td>Montefiore Medical Center</td>
<td>Technical assistance and direction for the Program for Hospital Initiatives in Long-Term Care (for 1 year). ID# 8895</td>
<td>273,979</td>
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<tr>
<td>National Academy of Sciences—Institute of Medicine</td>
<td>Technical assistance and direction for the Health Policy Fellowships Program (for 3 years). ID# 7582</td>
<td>559,300</td>
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<tr>
<td>National Academy of Sciences—National Research Council</td>
<td>Study on adolescent pregnancy and childbearing (for 21 months). ID# 9243</td>
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<tr>
<td>National Bureau of Economic Research, Inc.</td>
<td>Studies on improving health and health care (for 3 years). ID# 9448</td>
<td>188,734</td>
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<tr>
<td>The National Council on the Aging, Inc.</td>
<td>Pilot volunteer project to assist chronically ill children and their families (for 1.5 years). ID# 8790</td>
<td>185,637</td>
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<td>National Executive Service Corps</td>
<td>Development of a senior executive program to aid hospitals (for 1 year). ID# 9594</td>
<td>99,600</td>
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<td>National Foundation for Dentistry for the Handicapped</td>
<td>A prepaid dental program for the developmentally disabled (for 2 years). ID# 8918</td>
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<td>National Fund for Medical Education</td>
<td>Support for summer programs for minority premedical students (for 1 year). ID# 8121</td>
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<td>New Brunswick Development Corporation</td>
<td>Redevelopment program for New Brunswick, New Jersey (for 2 years). ID# 9280</td>
<td>1,000,000</td>
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<td>New England Medical Center Hospitals</td>
<td>Decentralizing the management of a teaching hospital (for 2 years). ID# 9395</td>
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<td>Boston, Massachusetts</td>
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<td>Description</td>
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<tr>
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<tr>
<td>New Jersey Hospital Association</td>
<td>Princeton, New Jersey</td>
<td>Implementation of a statewide network of personal emergency response systems (for 3 years).</td>
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<tr>
<td>New York University</td>
<td>New York, New York</td>
<td>Technical assistance and direction for the Rural Hospital Program of Extended-Care Services (for 1 year).</td>
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<tr>
<td>University of North Carolina at Chapel Hill</td>
<td>Chapel Hill, North Carolina</td>
<td>Development/Technical assistance for Infant Health and Development Program (for 1 year).</td>
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<tr>
<td>University of North Carolina at Chapel Hill, Health Services Research Center</td>
<td>Chapel Hill, North Carolina</td>
<td>Evaluation of the need for rural health center practice subsidies (for 1 year).</td>
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<td></td>
<td>Technical assistance and direction for the Dental Services Research Scholars Program (for 1 year).</td>
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<tr>
<td>Ohio Presbyterian Homes</td>
<td>Columbus, Ohio</td>
<td>Strengthening the delivery of services to the frail elderly (for 2 years).</td>
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<tr>
<td>University of Oregon Development Fund</td>
<td>Eugene, Oregon</td>
<td>Study of program reforms in long-term care in Oregon (for 23 months).</td>
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<tr>
<td>Pace University, Graduate School of Nursing</td>
<td>Pleasantville, New York</td>
<td>Planning a university-wide health service managed by the nursing faculty (for 6 months).</td>
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<tr>
<td>The University of Pennsylvania, School of Medicine</td>
<td>Philadelphia, Pennsylvania</td>
<td>Study of variation in ancillary services utilization (for 2 years).</td>
</tr>
<tr>
<td>The University of Pennsylvania, School of Nursing</td>
<td>Philadelphia, Pennsylvania</td>
<td>Technical assistance and direction for the Teaching Nursing Home Program (for 1 year).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Program to improve health outcomes for teenage mothers and their infants (for 4 months).</td>
</tr>
<tr>
<td>Program for Prepaid Managed Health Care</td>
<td>Collaboration of medical institutions with state and federal government and private insurers in projects offering health care by combining patient care management by primary care physicians with a capitated payment arrangement (for the periods indicated). ID# 7862</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Case Western Reserve University, School of Medicine</strong>&lt;br&gt;Cleveland, Ohio&lt;br&gt;(25 months)</td>
<td>$1,200,000</td>
<td></td>
</tr>
<tr>
<td><strong>Chesapeake Health Plan, Inc.</strong>&lt;br&gt;Baltimore, Maryland&lt;br&gt;(2 years)</td>
<td>623,700</td>
<td></td>
</tr>
<tr>
<td><strong>Children's Health Systems, Inc.</strong>&lt;br&gt;San Diego, California&lt;br&gt;(2 years)</td>
<td>1,016,070</td>
<td></td>
</tr>
<tr>
<td><strong>City of Cincinnati, Board of Health</strong>&lt;br&gt;Cincinnati, Ohio&lt;br&gt;(2 years)</td>
<td>955,900</td>
<td></td>
</tr>
<tr>
<td><strong>The Johns Hopkins Hospital</strong>&lt;br&gt;Baltimore, Maryland&lt;br&gt;(2 years)</td>
<td>934,495</td>
<td></td>
</tr>
<tr>
<td><strong>Lutheran Medical Center</strong>&lt;br&gt;Brooklyn, New York&lt;br&gt;(2 years)</td>
<td>1,059,569</td>
<td></td>
</tr>
<tr>
<td><strong>The Medical College of Pennsylvania</strong>&lt;br&gt;Philadelphia, Pennsylvania&lt;br&gt;(2 years)</td>
<td>862,988</td>
<td></td>
</tr>
<tr>
<td><strong>Mile Square Health Center, Inc.</strong>&lt;br&gt;Chicago, Illinois&lt;br&gt;(2 years)</td>
<td>881,334</td>
<td></td>
</tr>
<tr>
<td><strong>Public Health Trust of Dade County, Florida</strong>&lt;br&gt;Miami, Florida&lt;br&gt;(2 years)</td>
<td>741,835</td>
<td></td>
</tr>
<tr>
<td><strong>University of Utah, College of Medicine</strong>&lt;br&gt;Salt Lake City, Utah&lt;br&gt;(2 years)</td>
<td>855,252</td>
<td></td>
</tr>
<tr>
<td><strong>Watts Health Foundation, Inc.</strong>&lt;br&gt;Los Angeles, California&lt;br&gt;(2 years)</td>
<td>995,304</td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>Location</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>West Alabama Health Services, Inc.</td>
<td>Eutaw, Alabama</td>
<td>(2 years)</td>
</tr>
<tr>
<td>University of Wisconsin Medical School</td>
<td>Madison, Wisconsin</td>
<td>(2 years)</td>
</tr>
<tr>
<td>Rand Corporation</td>
<td>Santa Monica, California</td>
<td>Effect of geriatric nurse practitioners on improving nursing home care (for 3 years).</td>
</tr>
<tr>
<td>St. Peter’s Medical Center, School of Nursing</td>
<td>New Brunswick, New Jersey</td>
<td>Support for a nurse training program (for 10 months).</td>
</tr>
<tr>
<td>St. Vincent’s Hospital and Medical Center of New York</td>
<td>New York, New York</td>
<td>Technical assistance and direction for the Health Care for the Homeless Program (for 1 year).</td>
</tr>
<tr>
<td>The Salvation Army</td>
<td>New Brunswick, New Jersey</td>
<td>Program of assistance to the indigent (for 1 year).</td>
</tr>
<tr>
<td>University of South Florida, College of Medicine</td>
<td>Tampa, Florida</td>
<td>Technical assistance and direction for the Rural Infant Care Program (for 1 year).</td>
</tr>
<tr>
<td>Stanford University, School of Medicine</td>
<td>Stanford, California</td>
<td>Technical assistance for and evaluation of the Infant Health and Development Program (for 1 year).</td>
</tr>
<tr>
<td>Tulane Medical Center</td>
<td>New Orleans, Louisiana</td>
<td>Program to increase minority enrollment in medical schools (for 2 years).</td>
</tr>
<tr>
<td>United Way of Central Jersey, Inc.</td>
<td>Milltown, New Jersey</td>
<td>Support of 1984 campaign (for 1 year).</td>
</tr>
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</table>

**PRESIDENT'S GRANTS**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Location</th>
<th>Description</th>
<th>ID#</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>The Academy for State and Local Government</td>
<td>Washington, D.C.</td>
<td>Exploration of options for health care for the medically indigent (for 5 months).</td>
<td>ID#9755</td>
<td>22,874</td>
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<tr>
<td>American Public Health Association, Inc.</td>
<td>Washington, D.C.</td>
<td>Implications of National Preventive Dentistry Program on public health dentistry (for 6 months).</td>
<td>ID#9747</td>
<td>5,319</td>
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<tr>
<td>Association of American Indian Physicians</td>
<td>Oklahoma City, Oklahoma</td>
<td>Feasibility study for evaluation of a model diabetes program (for 6 months).</td>
<td>ID#9552</td>
<td>35,881</td>
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<tr>
<td>Institution</td>
<td>Description</td>
<td>Amount</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------</td>
<td>----------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>University of California, Los Angeles, School of Medicine</td>
<td>Cost containment study in treating acute ischemic heart disease (for 1 year). ID#9095</td>
<td>$46,405</td>
<td></td>
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<tr>
<td>Children's Hospital National Medical Center</td>
<td>Feasibility study of pediatric home care (for 9 months). ID#9514</td>
<td>49,991</td>
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<tr>
<td>Concerned Citizens for Chronic Psychiatric Adults</td>
<td>Establishment of a group home with Rutgers Community Mental Health Center (for 1.5 years). ID#8916</td>
<td>15,000</td>
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<tr>
<td>Educational Testing Service — Education Policy Research Institute</td>
<td>Study of programs to increase minority enrollment in medical education (for 2 months). ID#9333</td>
<td>21,000</td>
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<tr>
<td>Hospital Research and Educational Trust</td>
<td>Update and expansion of inventory of U.S. health care data bases (for 10 months). ID#8654</td>
<td>24,320</td>
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<tr>
<td>Illinois Department of Public Health</td>
<td>Pre-evaluation study of a teen parent program (for 5 months). ID#9190</td>
<td>40,000</td>
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<tr>
<td>Jersey Shore Medical Center — Fitkin Hospital</td>
<td>Feasibility of a hospital-based health program for the elderly (for 9 months). ID#9136</td>
<td>25,000</td>
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<tr>
<td>The Johns Hopkins Hospital</td>
<td>Final meeting of the Municipal Health Services Program principals (for 2 months). ID#9705</td>
<td>16,657</td>
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<tr>
<td>The Johns Hopkins University, School of Hygiene and Public Health</td>
<td>Providing access to evaluation data on the Regional Perinatal Program (for 14 months). ID#9382</td>
<td>41,625</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State of Maine, Department of Human Services</td>
<td>National training workshop to foster replication of Maine child death study (for 4 months). ID#9698</td>
<td>40,000</td>
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<tr>
<td>University of Massachusetts</td>
<td>Planning the evaluation of the Health Care for the Homeless Program (for 7 months). ID#9595</td>
<td>36,532</td>
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<td></td>
<td>Analysis of medical records of New York clinics for homeless persons (for 5 months). ID#9730</td>
<td>49,194</td>
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<td>Organization</td>
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<td>Description</td>
<td>ID#</td>
<td>Amount</td>
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<tr>
<td>----------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>------</td>
<td>--------</td>
</tr>
<tr>
<td>University of Michigan, Health Administration Press</td>
<td>Ann Arbor, Michigan</td>
<td>Publication assistance for RWJF-supported research projects (for 1 year). ID#9504</td>
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<td>$10,000</td>
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<tr>
<td>Middlesex-Somerset-Mercer Regional Study Council</td>
<td>Princeton, N.J.</td>
<td>Central New Jersey transportation study project (for 10 months). ID#9501</td>
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<td>10,000</td>
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<tr>
<td>Mount Sinai School of Medicine of the City University of New York</td>
<td>New York, New York</td>
<td>Development of a communication device for impaired hospital patients (for 15 months). ID#9093</td>
<td></td>
<td>40,971</td>
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<tr>
<td>National Academy of Sciences</td>
<td>Washington, D.C.</td>
<td>Independent appraisal of the Institute of Medicine (for 1 year). ID#9438</td>
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<td>20,000</td>
</tr>
<tr>
<td>National Academy of Sciences—Institute of Medicine</td>
<td>Washington, D.C.</td>
<td>Dissemination of a report on prevention of low birthweight (for 1 year). ID#9697</td>
<td></td>
<td>19,751</td>
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<tr>
<td>The National Citizens' Coalition for Nursing Home Reform</td>
<td>Washington, D.C.</td>
<td>Study of nursing home quality of care (for 1 year). ID#9137</td>
<td></td>
<td>49,570</td>
</tr>
<tr>
<td>National Conference of State Legislatures</td>
<td>Denver, Colorado</td>
<td>Health care cost containment project (for 1 year). ID#9263</td>
<td></td>
<td>29,329</td>
</tr>
<tr>
<td>National Governors' Association</td>
<td>Washington, D.C.</td>
<td>Project to improve health care coverage for needy children (for 8 months). ID#9144</td>
<td></td>
<td>49,669</td>
</tr>
<tr>
<td>Northwestern University, J.L. Kellogg Graduate School of Management</td>
<td>Evanston, Illinois</td>
<td>Study of factors influencing hospital provision of ambulatory care (for 1 year). ID#9181</td>
<td></td>
<td>50,000</td>
</tr>
<tr>
<td>New York University, Graduate School of Public Administration</td>
<td>New York, New York</td>
<td>Study of health services management initiatives (for 8 months). ID#10065</td>
<td></td>
<td>17,102</td>
</tr>
<tr>
<td>Oregon Bioethics Conference, Inc.</td>
<td>Portland, Oregon</td>
<td>Program for community involvement in health care issues (for 6 months). ID#8989</td>
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<td>10,000</td>
</tr>
<tr>
<td>Institution</td>
<td>Description</td>
<td>ID#</td>
<td>Amount</td>
<td></td>
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<tr>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>University of Pittsburgh, School of Dental Medicine</td>
<td>Study of dental radiography for health screening (for 1 year).</td>
<td>9555</td>
<td>$25,117</td>
<td></td>
</tr>
<tr>
<td>Pittsburgh, Pennsylvania</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Society of Teachers of Family Medicine Foundation</td>
<td>Survey of alumni of faculty development programs to assess teaching needs (for 1.5 years).</td>
<td>9632</td>
<td>6,000</td>
<td></td>
</tr>
<tr>
<td>Kansas City, Missouri</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Twin Cities Public Television, Inc.</td>
<td>Outreach activities associated with a child health television series (for 1 year).</td>
<td>9437</td>
<td>20,000</td>
<td></td>
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<tr>
<td>St. Paul, Minnesota</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University of Medicine and Dentistry of New Jersey</td>
<td>Planning program with New Brunswick's two hospitals (for 2 years).</td>
<td>9252</td>
<td>11,500</td>
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<tr>
<td>Newark, New Jersey</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Visiting Homemaker Home Health Aide Service of Middlesex County, Inc.</td>
<td>Companionship program for the frail, homebound elderly (for 1 year).</td>
<td>9811</td>
<td>10,000</td>
<td></td>
</tr>
<tr>
<td>North Brunswick, New Jersey</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yale University</td>
<td>Implications of changes in Canada's Medicare system for the United States (for 3 months).</td>
<td>9568</td>
<td>11,322</td>
<td></td>
</tr>
<tr>
<td>New Haven, Connecticut</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth Employment Service of Princeton, Inc.</td>
<td>Expansion of an intergenerational program (for 1 year).</td>
<td>9456</td>
<td>4,300</td>
<td></td>
</tr>
<tr>
<td>Princeton, New Jersey</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total 1984 grants</strong></td>
<td><strong>$59,371,699</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Refunds of prior years' grants</strong></td>
<td>(249,731)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cancellations of prior years' grants</strong></td>
<td>(1,384,724)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transfer of grants</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance returned by original grantees</td>
<td>(3,439,861)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transferred to new grantees</td>
<td>3,439,861</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Grants net for 1984</strong></td>
<td><strong>$57,737,244</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Bibliography
Book chapters


Journal articles


Book chapters


Journal articles


Cluff, Leighton E. “Economic Incentives of Faculty Practice: Are They Distorting the Medical School’s Mission?” JAMA, 250(21):2931-2934, December 2, 1983.


**Audiovisual materials**


*Joint Ventures Between Hospitals and Physicians for Ambulatory Care: Conflict or Cooperation* (four 60 minute videotapes of a teleconference; recorded September 21, 1983). Chicago: American Hospital Association, 1984.

**Reports**


Financial statements
Introduction to financial statements

The annual financial statements for the Foundation for 1984 appear on pages 61 through 64. A listing of grants authorized in 1984 begins on page 37.

Grants authorized in 1984, net of cancellations and refunds of prior years’ grants, totaled $57,737,244. Program development, evaluation, administrative and investment expenses for the year came to $6,499,754; and federal excise tax on income amounted to $1,504,229, making a grand total of expenditures of $65,741,227. This total was $9,839,822 less than gross investment income of $75,581,049. In 1983, total expenditures were $4,600,258 less than gross revenue.

A list of investment securities held at December 31, 1984 is available upon request to the Treasurer, The Robert Wood Johnson Foundation, Post Office Box 2316, Princeton, New Jersey 08540.

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, 1984 and 1983 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 financial statements referred to above present fairly the financial position of The Robert Wood Johnson Foundation at December 31, 1984 and 1983 and the investment income, expenses, grants and changes in foundation principal for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Coopers & Lybrand

Newark, New Jersey
January 18, 1985
The Robert Wood Johnson Foundation
Statement of assets, liabilities and Foundation principal
at December 31, 1984 and 1983

<table>
<thead>
<tr>
<th>Assets</th>
<th>1984</th>
<th>1983</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$ 336,821</td>
<td>$ 301,151</td>
</tr>
<tr>
<td>Investments (at cost, or market value on dates of gifts)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Note 2):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Johnson &amp; Johnson common stock</td>
<td>181,555,501</td>
<td>185,217,742</td>
</tr>
<tr>
<td>19,000,000 shares in 1984, 19,383,258 shares</td>
<td></td>
<td></td>
</tr>
<tr>
<td>in 1983 (quoted market value $686,375,000 and $792,290,670)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed income investments (quoted market value)</td>
<td>471,839,399</td>
<td>441,726,659</td>
</tr>
<tr>
<td>$478,391,830 and $438,517,784)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program related investments</td>
<td>2,550,000</td>
<td>1,600,000</td>
</tr>
<tr>
<td>Land, building, furniture and equipment at</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cost, net of depreciation (Note 1)</td>
<td>6,182,684</td>
<td>5,493,650</td>
</tr>
<tr>
<td></td>
<td>$662,464,405</td>
<td>$634,339,202</td>
</tr>
</tbody>
</table>

| Liabilities and Foundation principal        |               |               |
| Liabilities                                 |               |               |
| Unpaid grants (Note 1)                      | $106,413,521  | $ 96,951,485  |
| Federal excise tax payable                  | 1,631,602     | 3,037,623     |
| Total liabilities                           | 108,045,123   | 99,989,108    |
| Foundation principal                        | 554,419,282   | 534,350,094   |
|                                             | $662,464,405  | $634,339,202  |

See notes to financial statements.
The Robert Wood Johnson Foundation  
Statement of investment income, expenses, grants and changes in Foundation principal  
for the years ended December 31, 1984 and 1983

<table>
<thead>
<tr>
<th></th>
<th>1984</th>
<th>1983</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Investment income:</strong></td>
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</tr>
<tr>
<td>Dividends</td>
<td>$ 22,775,328</td>
<td>$ 21,807,002</td>
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<tr>
<td>Interest</td>
<td>52,805,721</td>
<td>44,429,201</td>
</tr>
<tr>
<td></td>
<td>75,581,049</td>
<td>66,236,203</td>
</tr>
<tr>
<td>Less: Federal excise tax</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment expenses</td>
<td>369,558</td>
<td>275,341</td>
</tr>
<tr>
<td></td>
<td>73,707,262</td>
<td>64,641,645</td>
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<tr>
<td><strong>Expenses:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program development and evaluation</td>
<td>4,492,739</td>
<td>3,743,785</td>
</tr>
<tr>
<td>General administration</td>
<td>1,637,457</td>
<td>1,439,083</td>
</tr>
<tr>
<td></td>
<td>6,130,196</td>
<td>5,182,868</td>
</tr>
<tr>
<td><strong>Income available for grants</strong></td>
<td>67,577,066</td>
<td>59,458,777</td>
</tr>
<tr>
<td>Grants, net of refunds and cancellations</td>
<td>57,737,244</td>
<td>54,858,519</td>
</tr>
<tr>
<td></td>
<td>9,839,822</td>
<td>4,600,258</td>
</tr>
<tr>
<td><strong>Adjustments to Foundation principal:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital gains on sale of securities</td>
<td>10,228,266</td>
<td>114,265,916</td>
</tr>
<tr>
<td>less related federal excise tax</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Note 3)</td>
<td>1,100</td>
<td>200</td>
</tr>
<tr>
<td>Contributions received</td>
<td>10,229,366</td>
<td>114,266,116</td>
</tr>
<tr>
<td><strong>Net increase in Foundation principal</strong></td>
<td>20,069,188</td>
<td>118,866,374</td>
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<tr>
<td>Foundation principal, beginning of year</td>
<td>534,350,094</td>
<td>415,483,720</td>
</tr>
<tr>
<td><strong>Foundation principal, end of year</strong></td>
<td>$554,419,282</td>
<td>$534,350,094</td>
</tr>
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</table>

See notes to financial statements.
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, 1984 unpaid grants are as follows:

<table>
<thead>
<tr>
<th>Year Grant Authorized</th>
<th>Amount Unpaid at December 31, 1984</th>
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<tbody>
<tr>
<td>1980</td>
<td>$947,562</td>
</tr>
<tr>
<td>1981</td>
<td>7,421,610</td>
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<tr>
<td>1982</td>
<td>15,717,193</td>
</tr>
<tr>
<td>1983</td>
<td>30,406,929</td>
</tr>
<tr>
<td>1984</td>
<td>51,920,227</td>
</tr>
<tr>
<td></td>
<td><strong>$106,413,521</strong></td>
</tr>
</tbody>
</table>

Depreciation of $228,547 in 1984 and $201,498 in 1983 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 value of the sizeable investment in Johnson & Johnson common stock does not necessarily represent the realizable value of such investment.

3. The net capital gains on sales of securities for the years ended December 31, 1984 and 1983 were as follows:

<table>
<thead>
<tr>
<th></th>
<th>1984</th>
<th>1983</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johnson &amp; Johnson common stock</td>
<td>$9,767,461</td>
<td>$109,652,193</td>
</tr>
<tr>
<td>Other securities, net</td>
<td>460,805</td>
<td>4,613,723</td>
</tr>
<tr>
<td></td>
<td><strong>$10,228,266</strong></td>
<td><strong>$114,265,916</strong></td>
</tr>
</tbody>
</table>

4. 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 expenses were $343,304 and $289,859 in 1984 and 1983, respectively.
Secretary's report
Secretary's report *

The Foundation lost two valued trustees emeriti with the deaths of Judge Klemmer Kalteissen and John H. Hoagland in 1984. Each one gave generously of his time and energy, and we are indebted to both of them for their leadership and service to the Foundation.

At the December meeting of the board, Wayne J. Holman, Jr., was elected to the office of trustee emeritus of the Foundation, having served as trustee of the Foundation for over 21 years. Upon his election as trustee emeritus, Mr. Holman was cited by the board for his loyal and distinguished service to the Foundation.

Staff changes
At its July meeting the Board of Trustees elected Drew E. Altman, Ph.D., to the office of vice president. In January 1985 Annie Lea Shuster was promoted to senior program officer.

Jeffrey C. Merrill, M.P.H., joined the Foundation in July as assistant vice president. Mr. Merrill previously was the director of the Center for Health Policy Research Studies at Georgetown University and a senior program consultant to the Foundation for data research and analysis. He has a master’s degree in public health from The Johns Hopkins University.

Rolando A. Thorne, M.P.H., joined the staff in March as program officer. Prior to joining the Foundation Mr. Thorne worked as the assistant to the director of Montefiore Medical Center in New York City. He received his master’s degree in public health from Yale University.

Peter Goodwin, M.B.A., joined the Foundation in July as financial analyst. Before joining the Foundation Mr. Goodwin worked at Beth Israel Medical Center in New York City. He received a master’s degree in business administration from Baruch College, City University of New York.

Carolyn H. Asbury, Ph.D., joined the staff in September as program officer. Dr. Asbury received her Ph.D. from the Wharton School, The University of Pennsylvania. Prior to coming to the Foundation she finished her work as a senior fellow at the Leonard Davis Institute of Health Economics, The University of Pennsylvania.

Also in September Alan B. Cohen, Sc.D., joined the Foundation as program officer. Dr. Cohen received his Sc.D. from the Harvard School of Public Health and since 1981 had been working at the Center for Hospital

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*To present as up-to-date a picture of staff changes as possible, this report covers the period through February 15, 1985.
Finance and Management and the Department of Health Policy and Management at The Johns Hopkins School of Hygiene and Public Health. Stephen A. Somers, Ph.D., joined the staff in October as program officer. Dr. Somers received his Ph.D. from Stanford University. Prior to joining the staff Dr. Somers served on the staff of the U.S. Senate Special Committee on Aging.

F. Catherine McCaslin, Ph.D., program officer, left the Foundation in March to assume a position at The University of Pennsylvania as project director of the National Study of Variation of Ancillary Services. Dr. McCaslin came to the Foundation in 1980 and helped to develop our grant programs in long-term care and research and development.

James P. Firman, Ed.D., senior program officer, left in May and moved to the Washington, D.C. area to establish a senior health care cooperative. Dr. Firman started at the Foundation in 1981 and was involved in our health-impaired elderly programs.

Philip J. Driscoll, M.B.A., financial analyst, who joined the Foundation in July 1980, left in June to become a consultant with Coopers & Lybrand in New York City.

Barbara H. Kehrer, Ph.D., senior program officer, left in July to become vice president of the Kaiser Family Foundation in California. At The Robert Wood Johnson Foundation Dr. Kehrer was involved in research projects related to grantee activities.

**Senior program consultants**

Jack Hadley, Ph.D., was appointed a senior program consultant for data research and analysis. Dr. Hadley is director of the Center for Health Policy Research Studies at Georgetown University.

Wendy Everett Watson, Sc.D., completed her assignment directing the Foundation’s Teaching Hospital General Medicine Group Practice Program. At the time Dr. Watson was appointed senior program consultant in 1982, she was the vice president of ambulatory and community health services at Brigham and Women’s Hospital. Dr. Watson has since assumed a position as program officer with the Kaiser Family Foundation.

**Board activities**

The Board of Trustees met five times in 1984 to conduct business, review proposals, and appropriate funds. In addition, the Policy, Finance, and Audit Committees met as required to consider and prepare recommendations to the board.

J. Warren Wood, III

*Vice President, General Counsel, and Secretary*
Application for grants
The Robert Wood Johnson Foundation is a private philanthropy interested in improving health in the United States. We are concentrating our resources on three well-defined needs in health:

- the need to improve access to personal health care for the most underserved population groups;
- the need to make health care arrangements more effective and care more affordable; and
- the need to help people maintain or regain maximum attainable function in their everyday lives.

To increase the potential impact of our grant funds within our three areas of interest, we have further defined our role to assist:

- development and testing of new and previously untried approaches to health care problems;
- demonstrations to objectively assess the operational effectiveness and value of selected new health care arrangements and approaches that have been shown to be effective in more limited settings; and
- projects designed to promote the broader diffusion of programs that have been objectively shown to improve health status or to make health care more affordable.

We give priority to proposed programs and projects that address regional or national problems. The one exception to this and our other guidelines is support for a small number of activities in New Brunswick, New Jersey, where the Foundation originated.

Policy guidelines established by our Board of Trustees will normally preclude support for the following types of activities: (1) ongoing general operating expenses; (2) endowment, construction, or equipment; (3) basic biomedical research; (4) international activities or programs and institutions in other countries; and (5) direct support to individuals.

Also, we do not support programs concerned solely with a specific disease or with broad public health problems, except as they might relate to our three areas of interest. The decision not to support such programs, worthy though they are, in no way implies a failure to recognize their importance. It is simply a consequence of the conviction that progress in the areas we have selected depends in large measure on our ability to
concentrate our funds. Unfortunately, even within our program interests and
guidelines, requests have always exceeded our resources, and thus we are
unable to support many deserving proposals.

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

Proposal letters should be addressed to:

Edward H. Robbins, Proposal Manager
The Robert Wood Johnson Foundation
Post Office Box 2316
Princeton, New Jersey 08540.
Figures by Leonard Lee Ringel
Illustrations by Jeff Cornell
Printed in the United States of America
by Wm. F. Fell Company, Philadelphia