Inside The ‘Quiet Giant’ With The W.K. Kellogg Foundation’s President

Thoughts on philanthropy, health system change, and health care research from W.K. Kellogg Foundation President William C. Richardson.

by John K. Iglehart

Kellogg’s History And Current Funding Priorities

Q: The W.K. Kellogg Foundation has a rich history dating from the 1930s. Please depict briefly the foundation’s beginnings and its guiding philosophy.
A: The foundation was established in 1930 when W.K. Kellogg, the cereal industry pioneer, donated to it more than $66 million in Kellogg Company stock and other investments. The foundation trust continues to own substantial equity in the Kellogg Company, and the two organizations have enjoyed a long-standing relationship. The foundation is governed by an independent board of trustees. The foundation was established by W.K. Kellogg with this primary goal in mind: to help people help themselves through the practical application of knowledge and resources so as to improve their quality of life and that of future generations.

Q: Were W.K. Kellogg’s interests eclectic or tightly focused on a few areas?
A: Early on, his interests included the development of community health care, which he distinguished from medical care that was being provided by physicians and hospitals in southwestern Michigan. He also took a strong interest in young people, particularly those who lived in rural areas. He put up matching dollars to encourage school districts to consolidate in an effort to achieve a greater critical mass and, therefore, attract better teachers. He believed in building the capacities of communities and in developing community partnerships.

Q: When did you become the foundation’s president and chief executive officer, and how large is its staff and annual grant making?
A: I became president and CEO on 1 August 1995, but, before that, I had enjoyed a thirty-year association with the foundation as a fellow, grantee, and consultant. My two immediate predecessors, Emory Morris and Russell Mawby, served a combined fifty-three years in the position. The foundation has a staff of about 270 people, assets of about $7.5 billion, and annual grant-making and program payments of about $300 million.

Q: What are the foundation’s major program areas?
A: Reflecting W.K. Kellogg’s original vision, the foundation continues to focus its resources on four broad areas of programming. The first is health, particularly primary care, public health, and health professions education. The second is food systems and rural development, including natural resource conservation and economic development. The third is youth and education, and the fourth is the fields of philanthropy and volunteerism. We also pursue crosscutting themes, including strengthening community leadership; addressing information systems and technology issues; capitalizing on diversity by addressing issues of race and ethnicity; and supporting families, neighborhoods, and communities.

Major Contributions To Society

Q: What do you regard as the foundation’s major contributions to society?
A: Kellogg’s early investment in community...
colleges was instrumental in making these educational institutions a major force within our society. Adult education, particularly part-time education for people who hold full-time jobs, was an early Kellogg idea in which the foundation has invested now for five decades. Our support for the development of distance education, for instance, accelerated the professionalization of nursing. Kellogg also contributed substantially to the development of local health departments, particularly in rural areas. Other major advancements assisted by Kellogg support are training programs for primary care and public health professionals, studies in preventive dentistry, and fluoridation of drinking water.

Q: Has the foundation focused its resources on funding the latest innovation or models, or has it tried to identify its own innovations?
A: I would say Kellogg has focused much more on innovating than trying to scale up existing models. Its pattern of innovation has been consistent throughout its sixty-seven-year history. That is, Kellogg has sought to encourage innovation at the individual community level and institutional level. For example, Kellogg invested heavily in building programs in health administration until it felt there was adequate capacity to train the next generation of professionals. We also have followed that pattern in Latin America. Over a fifty-year period, Kellogg has strengthened the capacity of higher education institutions throughout that region.

Grant-Making Facts And Figures

Q: Geographically, what percentage of your grant making is devoted to Michigan?
A: I don’t know the exact figure, but it is a relatively modest amount in comparison with other foundations that have a geographic home. We think of ourselves as a midwestern foundation with an international reach. We budgeted about $7 million for the Battle Creek area during fiscal year 1996, out of a total of $252 million in program payments.

Q: What amount of your total grant making is devoted to health-related activities?
A: It’s about $50 million.

Q: Do you envision that percentage changing over the next five to ten years?
A: We operate based on a rolling five-year plan. We are currently developing the next iteration of that plan, and we are holding fairly steady in the percentage of grant funds devoted to health activities. Now, the initiatives will change. What we are doing is not so much individual grant making, but rather identifying areas in which we want to work. An example would be primary care partnership programs, where we are promoting collaboration between communities and medical and nursing schools with the idea of moving health professions education out into the community. We have just begun a similar effort involving graduate nursing and postgraduate medical education. We have had a community-based public health program that was designed in a similar way. We now are launching a new initiative in public health with The Robert Wood Johnson Foundation that will involve both the state and community levels.

Q: What is your early thinking on the directions that this new Kellogg–Johnson initiative will take?
A: I hope for a broader national consensus on a vision of public health and public health services for the next century. Some rearrangement of public health care delivery is already occurring without benefit of a shared vision. New public/private partnerships and more effective collaboration are required to protect the essential functions of traditional public health. I favor a broader pursuit of population-based health approaches that go well beyond the provision of medical services. I would like to see some public/private partnerships with managed care organizations, particularly those that are organized around a region or metropolitan area. Such collaborations could help communities to keep better track of a set of public health issues that need to be addressed, while drawing upon providers for clinical services.

Devolution To States

Q: In recent months Kellogg has made several large grants to national organizations. These grant awards seem out of character
for a foundation that has focused its activities on the community level. Is Kellogg embarking in new directions?

A: In June of 1996 Kellogg launched a $21 million initiative to address issues around the distribution of responsibility between federal and state governments. The modern term for the shift of authority from federal to state governments is devolution. The devolution of authority over health and welfare policies will, for better or worse, directly affect the personal well-being of tens of millions of Americans in ways that are far from clear. Devolution on this scale is essentially an untried social experiment. Little research or practical knowledge exists on how devolution will affect states and society. It is at this entry point that we see a clear role for foundations.

Q: What is that role in relation to the grants mentioned earlier?

A: The fast pace of devolution has placed immediate demands on governments and communities. To help these entities work together, our effort will try to lower the visible and invisible barriers to access that prevent citizens' voices from being heard. Our grant to the National Association of State-Based Child Advocacy Organizations is an example of the strategy. This two-year, $991,880 grant will support technical assistance and seminars to give local leaders a basic understanding of how and why policies are made.

A three-year, $5,095,015 grant to Families USA Foundation will help to construct another infrastructure for informed citizen involvement in health care change. To enable community organizations and leaders to have a voice in change, Families USA will provide a three-tiered approach to educating the public: (1) Policy briefs and technical guides about issues such as managed care and other Medicaid reforms will be written and distributed to concerned communities; (2) Families USA will furnish nine states (California, Illinois, Louisiana, Minnesota, Mississippi, Missouri, New Mexico, North Carolina, and Oregon, and others may be added later) and the District of Columbia with technical assistance and training that will target the particular needs of community groups in those states; and (3) it will work with organizations in the same ten jurisdictions to help strengthen the ability of vulnerable groups to become effective community change agents in the health care reform process.

Through a three-year, $6 million grant, the W.K. Kellogg Foundation is joining with The Annie E. Casey Foundation, The Henry J. Kaiser Family Foundation, and a number of other funders to support The Urban Institute’s efforts to closely monitor the primary social and health indicators affected by devolution.

We have also awarded the Rockefeller Institute at the State University of New York at Albany a four-year, $2,000,744 grant to contribute to Kellogg’s devolution initiative by analyzing the way that state governments carry out their new responsibilities.

Finally, we have provided a two-year, $3.5 million grant to the National Leadership Coalition on Health Care, in Washington, D.C. The coalition will design and implement a social marketing and educational strategy campaign focusing on the importance of establishing a national policy to assure access to appropriate and affordable, high-quality health care. In addition to working with its member organizations, which employ or have a membership of approximately 100 million Americans, the coalition will sponsor national public forums concerning the American health care system at four presidential libraries and commission policy studies concerning challenges related to access, quality, and cost of health care in the United States.

While we do not plan significant expansion of our devolution work beyond these five grantees, we are considering proposals in two target areas: evaluation of the implications of the new federal and state welfare policies in large urban communities, and the implications of devolution on the sovereignty status of Native American tribes.

Q: Kellogg has been meticulous in maintaining a neutral, nonpartisan stance when it comes to politics. Yet, Families USA is a very activist, consumer-oriented organization that involved itself heavily in
advocating on behalf of the Clinton administration’s health care reform proposal. How do you reconcile that seeming contradiction?

A: We will continue to be, as you say, “meticulous.” While Families USA has been actively involved as an advocate in some past policy debates, the organization is also viewed as a credible analytical voice concerning health policy. It is guided by a bipartisan board of respected leaders. The work that Families USA will do for us will provide objective and usable information to local communities and organizations in a balanced way.

‘The Quiet Giant’

Q: Over the years Kellogg has granted hundreds of millions of dollars, but it has kept a very low profile. I have heard other foundation executives refer to Kellogg as “the quiet giant.” They know it supports many community-based activities, but they don’t seem to have a handle on the impact of these things. How do you respond to this kind of opinion about Kellogg?

A: Well, first, I think it’s true that Kellogg has kept a low profile. How much of a profile it will have in the future depends upon the degree to which having a higher profile serves our needs in terms of accomplishing our goals. With respect to our focus, it seems to me that in recent years we have come into pretty sharp focus in terms of limiting ourselves to initiatives rather than general grant making and being relatively proactive rather than reactive in what we’re seeking to accomplish. For example, I think of programs such as the African-American Men and Boys initiative, which got tremendous coverage last year. In that instance I believe we made a genuine difference in terms of the way in which the broader community and the African-American community viewed the best approach to providing support for this at-risk group of our population.

Q: You are chairman of the board of The Henry J. Kaiser Family Foundation. In contrast to Kellogg, Kaiser has a very activist, media-oriented profile. How do you explain these very different profiles?

A: I think a high, media-oriented profile is absolutely essential for what Kaiser is seeking to accomplish. That is, Kaiser devotes substantial resources to doing analysis of the impact of health policy activities as they relate to vulnerable populations. To make a difference with a relatively modest payout, Kaiser has chosen to devote itself to the analysis and dissemination of information and seeks to inform policymakers and the public.

Q: So leveraging its dollars through the media makes sense for Kaiser, but it is not an approach that Kellogg believes is appropriate for its goals?

A: Well, if we were devoting large resources to analytic work, if we were the source of information on Medicaid state by state, as Kaiser is through its Medicaid commission, then the only sensible thing to do would be to communicate that. But in many instances we’re trying to develop approaches to local problems and then disseminating that information through the networking of our grantees, rather than through a media strategy. Increasingly, Kellogg is helping community leaders—who are grantees—to develop the capacity to communicate their experiences both individually and collectively through national collaborative efforts. For two reasons, we believe this strategy will have a fundamental impact on national policy, both in the halls of government and in the health marketplace. First, our grantees across the country are demonstrating effective and creative alternatives to difficult and almost intractable problems. Second, one of the premises in the devolution of federal policy authority to the states and, in some instances, to the community and nonprofit sector is the opportunity for citizens to have a choice in policy decisions that were previously influenced heavily by more organized interests.

U.S. Philanthropy Today

Q: Step back for a minute and think more broadly about American philanthropy today. Is its return to society equal to the loss of revenue that derives from the tax-
free nature of its assets?

A: I think that foundations are doing better than ever in the sense that many philanthropies have moved beyond an individual grant-making approach that was palliative in many cases and from which relatively few lessons were learned. Today most midsize and large foundations are thinking much more strategically in terms of the way in which they use their resources. One example is the way Kaiser seeks to inform policymakers and the public. Another is the demonstration of large-scale initiatives like those of Robert Wood Johnson. A third is the development of capacity at the local level, which can then be replicated. These would include the W.K. Kellogg Foundation’s Families for Kids program, community-led health reform initiatives such as the Community Care Network, Comprehensive Community Health Models of Michigan, or the foundation’s primary health care professions or community-based public health programs.

Q: You have been the president of a great private university (Johns Hopkins) and provost of a well-respected state university (Penn State). What has struck you about the differences that separate institutions like these and a private philanthropy?

A: The thing that has struck me the most are the similarities rather than the differences, although there are significant differences. Penn State had twenty-three campuses, although the budget was about the same as Hopkins’, about $1.5 billion in each instance. Penn State had 72,000 students when I left, while Johns Hopkins had 16,000. The faculties of both institutions were obviously each much larger than the staff at Kellogg, which as I noted number around 270. One of the basic similarities among these three institutions is that they all need to attract very bright, very committed people who are in touch with their field, be it youth, health care, food systems, or in the case of Penn State and Hopkins, astronomy or history. But they also need to have people who understand the relationship between the university or foundation and the surrounding environment. I spent a lot of time at both Penn State and Hopkins figuring out how to connect the university to the citizenry, to public officials, to local neighborhoods, and to the private sector. The same holds true at Kellogg.

Q: How do you anticipate that Kellogg will help colleges and universities to make the necessary transitions to the twenty-first century?

A: I think that Kellogg will help universities to change the way in which they think of themselves in relation to their communities of interest. I think we have moved from a Cold War paradigm, if I could use that term, in which we measured universities on the degree to which they contributed to the Cold War effort, although it was never said in that way. I don’t think universities realized over the fifty or so years of the Cold War the degree to which they were captured by all of the organizational trappings that went with that kind of a purpose. We have to think of universities more in terms of contributing to the development of their undergraduate students, enlisting the faculty to mentor those students to become independent learners, incorporating adult learners, and addressing pressing societal issues and connecting with the rest of society. Kellogg and other foundations can certainly assist that effort.

We’re also eager to help higher education institutions promote and benefit from diversity. We support diversity through our programming in general but have also established important initiatives to serve historically black colleges and universities and tribal colleges. Our grants help these institutions to address community development and cultural aspects of communities and also improve educational outcomes for students. We also support collaboration between tribal colleges and so-
called mainstream colleges and universities.

Q: In terms of holding an executive accountable, whether he or she be a university president or a foundation president, how should performance be measured?

A: That's a very good question. At Hopkins I laid out for the board every year the issues the university was facing. And often I would include measures to indicate that if we got this far on resolving an issue it would be deemed a success. I did it in fairly general terms because we were dealing with such a wide range of issues. But we sought to measure our success against specific challenges such as securing matching funds for a legislative appropriation that could only be released if we raised $15 million in three months, or revising the academic curriculum in a particular school, or developing a fair system for reimbursing the university for its capital costs. I have been even more explicit at Kellogg in setting goals and measuring success. I have learned a good deal about making accountability as explicit as possible from serving on corporate boards.

Thoughts On Health System Change

Q: I am interested in your thoughts about America's rapidly changing health care system—the movement to greater commercialism, the erosion in professional authority, and the reduction of the labor skill mix in the nation's hospitals, to cite just three items. To begin, what is your view about the employment of market principles as the major way to allocate health care resources?

A: I have followed the evolution of market forces for a long time, dating from my days at the University of Washington in the early to mid-1970s. Ever since then I have thought that the introduction of market forces with the incentives running in the right direction was a healthy development. But reliance on market forces is not the whole answer. Such forces will not, by themselves, resolve the problems of uncompensated care, uninsured people, and people who are at particularly high medical risk. Unregulated managed care, in the absence of some sort of common insurance pool, is not going to work, because I don't believe society is going to be willing to say that a significant proportion of our population is just out of luck if they can't obtain coverage.

Q: Having said that, do you regard yourself as an advocate of a market-based system or somewhat more skeptical of it?

A: My view is that, first of all, it is here; second, that it's healthy, and we're seeing some positive effects. However, its evolution is at a rudimentary stage, and we've got a long way to go in terms of coverage and understanding who's at risk, understanding carve-outs and how to make them work, and making sure that the abuses that can be present in any system are addressed in the right way. Currently, it seems to me, we are addressing them in the wrong way in that Congress and fifty state legislatures are enacting bills that direct health plans to keep patients in the hospital so many days for one thing or another. To legislate at that level of detail makes no sense to me. We also need appropriate mechanisms to ensure protection of essential public health functions. We have achieved high standards of health in the United States through both our public health and medical care delivery systems.

Q: If that is not a sensible approach, what would you prefer in its place?

A: Let’s go to the other extreme and look at what might happen if, within communities, the involved and informed citizenry, both employers and the public, got together, examined data that were provided by a well-trusted private or public agency, and figured out what they wanted to have happen within that community's health care system. I have a feeling that you could develop a community consensus and direction on critical questions,
including approaches to take out excess capacity of hospitals; to develop primary care centers, particularly for vulnerable populations; and to create networks for remaining providers so that they could set some standards and develop some programs.

Q: What's your view of the conversion of much of the managed care industry from not-for-profit status to for-profit status? Does that give you pause, or is that in keeping with the value that Americans attach to capitalism?

A: Sure, it gives me pause because outside of an organized framework like Group Health of Puget Sound or Kaiser Permanente, it’s much harder to keep track of what physicians are doing under a capitated system. There are measurement systems available, but the level of sophistication needed to know what’s really going on in clinical decision making is currently beyond most of these systems. It makes me uneasy to have physicians being pulled in several directions in terms of their incentives, both primary care doctors and specialists, but particularly those in primary care. And having no organized framework with peer pressure on them, other than just the general market pressure, does give me pause. On the other hand, I would not slow down the movement to a market-based system. I have positive feelings about ways in which market forces are beginning to rationalize the system. We have tried just about every other approach—comprehensive health planning, regional medical programs, and price controls under President Nixon.

Q: You mentioned the mixed financial incentives under which physicians and nurses are working today in managed care settings. Do we expect too much of professionalism as a safeguard that helps to protect the patient? Are we asking physicians to be saints in a system that is increasingly driven by the profit motive?

A: I think so, but having said that, I don’t know what else we can do. We’re very fortunate to have a profession trained in the way that physicians and nurses are trained. It would be horrifying to consider what it would be like going through this passage if we didn’t have well-trained physicians and nurses who know the difference between right and wrong in terms of clinical decision making, not to say that there isn’t a lot of variation there.

Role Of Health Services Research

Q: You started your career in health services research, but you’ve been away from it for many years now. What is your view about that research community and its contribution to the formation of policy? Is it measuring up in your eyes?

A: I think it is: It has always been only one, obviously, of a number of major forces at work in formulating health policy. But now I think health services researchers have a new assignment—measuring the impact of the market-driven transformation that is under way. We need to know the impact on the disadvantaged and on those populations that do not have coverage. I think there is another important role, too, and that is providing good technical information on how to measure clinical outcomes, patient satisfaction, and how to adjust risk. We will always have to rely on professional judgment and ethics, but these things must be buttressed by good information in the clinical setting.

Q: Thank you.