



Giving Is ‘Where Love And Need Are One’

DAN McCORMACK

I had been reading Robert Frost’s poetry since elementary school, but I didn’t discover “Two Tramps in Mud Time” until I was in my 30s. It’s a fairly long poem; in it, Frost is splitting logs in his yard when he is approached by two out-of-work lumbermen who are looking to earn some money. The poet resists. While recognizing the tramps’ need for gainful employment, Frost simply is enjoying his labor too much to pay someone to do it for him. He closes the poem with this stanza:

But yield who will to their separation,
My object in living is to unite
My avocation and my vocation
As my two eyes make one in sight.
Only where love and need are one,
And the work is play for mortal stakes,
Is the deed ever really done
For Heaven and the future’s sakes.¹

For a long time, I filtered this poem through a personal, occupational prism. At those points in my professional life when I struggled with questions of direction and purpose, I sought to follow Frost’s objective to bring together in a common vision what I enjoy in my life and what I do for a living.

More recently, I have begun to contemplate the poem’s last four lines and to consider how love and need come together in the context of philanthropy. I wonder whether the place “where love and need are one” in health care fundraising has become unbalanced. Specifically, I worry that our institutions’ financial need (or perceived lack thereof) occupies too dominant a portion of our donors’ decision-making.

Using “Two Tramps” as analogy, our donors

are the poet, engaged in an effort that they love. Making a gift and splitting a log don’t require the same degree of physical exertion, of course, but there’s definitely effort involved in each. We fundraisers, on behalf of the institutions we serve, are the tramps looking for work. We speak to donors about our needs and ask them to support us. Our appeals are intended to state our needs in such a way that they trigger a positive emotional response.

A connection is made, and a gift is realized, when the donor’s love and the institution’s needs are aligned in a complementary relationship. On more occasions than I care to count, though, no matter how much warm feeling is engendered, I encounter donors who resist supporting our hospitals because they believe that the hospital doesn’t really need the money.

THE GIVING GAP

Multiple studies for years have confirmed the existence of a “Catholic giving gap.” Catholic donors give at roughly half the rate of Protestants. While these studies have tended to focus on congregational giving, that is, support for parishes, the gap is not limited to congregational giving



Roy Scott

alone. Catholics who made gifts to causes outside of their parishes, both religious and secular, also gave less than nearly all Protestant donors; only Lutherans donated less than Catholics to nonparish causes.²

Of course, not all donors to Catholic hospitals are Catholic, but the problem of fundraising appeals driven by financial need cuts across all faiths. Research done by the Catholic Social and Pastoral Research Initiative at the University of Notre Dame in Indiana demonstrated that across all religious denominations and congregations in the study, the focus on financial need — “paying the bills” — versus a more spiritual, mission-driven message correlated to decreased levels of giving.³

How does a hospital (or any nonprofit organization, for that matter) reach this place of imbalance, where the perceived lack of financial need overcomes the affection that a donor might feel for the institution? And how do we — as mission-driven organizations that genuinely need philanthropic support to advance that mission — bring our donors back to Frost’s place, “where love and need are one”?

The answer, I think, begins with the understanding that we — the fundraisers — have done a very good job, perhaps too good a job, of elevating the importance of financial need in the giving equation. We have conditioned our donors to think about the high costs involved in providing high-quality, compassionate health care: the replacement facility or renovated patient unit; that new piece of state-of-the-art diagnostic equipment; and our imperative to provide access for people who are indigent and uninsured. Even Catholic health care’s time-honored mantra of “no margin, no mission” advances the imbalance, because that expression establishes “margin” as the precondition to “mission”: Address your financial needs first, and the rest follows.

DONORS SEE BUSINESS ENTERPRISES

It was not always this way in health care philanthropy, or at least it didn’t feel like it. Many Catholic hospitals share the same history (and have the same series of sepia photographs on their boardroom walls): A group of women religious is called

to provide health care to a community; the first patients are treated in the front parlor of someone’s wood-frame house (sepia photo No. 1); the first multistoried brick hospital building is constructed in the early 20th century (sepia photo No. 2); a replacement hospital or large satellite facility is built in the 1950s or 60s, probably in a more suburban location (sepia photo No. 3).

Although the federal 1946 Hospital Survey and Construction Act (also called the Hill-Burton Act) subsidized much hospital and other health care facility replacement and expansion, philanthropy fueled all of it. Those same hospital histories illustrated with sepia photos invariably include stories of the sisters soliciting the support of donors. They needed philanthropy to sustain their mission and build their facilities. Even when

those early hospitals were viewed as financially successful (and had balance sheets to prove it), the donors didn’t seem to mind. Frankly, it may have been the presence of the sisters in the hospitals as both caregivers and administrators that both amplified the perception of institutional need and made it much easier to activate the donor’s sense of love for the institution.

Today’s donors, for the most part, see a different picture. As revenues increase, the hospitals become recognized as business enterprises. They merge into regional and national systems. If donors have been patients, they have received a bill for services that, even if fully paid by insurance, can be a staggering amount of money. If they are employers, they know the increasing premiums that they are paying to insure their workers. Even when they are our own hospital board members and have reviewed the business plans and understand how capital projects are being financed, they question the need for a fundraising campaign entirely. Why, they ask, should we be soliciting donors to support the purchase of a new piece of equipment that’s going to pay for itself anyway?

NONPROFIT ENTITIES

Instead of answering the question directly, our tendency has been to go around it. For example, we began to establish separate hospital founda-





tions rather than respond directly to the concern that donors might think hospitals don't need their contributions. We created new nonprofit entities to receive gifts, even though contributions made to a nonprofit hospital already were tax deductible.

There are many good reasons why hospitals choose to create separate hospital foundations, including the ability to segregate patient care revenue from philanthropic support and shield foundation assets from hospital liability. An independent foundation also produces a shift in donor perception: A hospital foundation is not perceived as a business enterprise, and it is therefore in a better position to make a need-based solicitation to donors, especially if those donors are patients who also had paid the hospital for services rendered.

Thus, we find ourselves caught in a money trap. When a donor questions the hospital's financial status, we engage in a discussion (or a polite argument) to convince them that, yes, the hospital really does need the money. We talk about the difference between what we charge and what we are paid; how Medicare and Medicaid cover only a fraction of actual expenses; about the exorbitant costs associated with medical technology and pharmaceuticals; how the capital needs of these 50-year-old facilities outstrip the capital dollars available to pay for them; about American health care's transition "from volume to value" and the fiscal upheaval it is causing across the country.

If we're really caught in the trap, we'll show our donors a graph that depicts the impossible number of inpatient admissions we would have to add each year to generate the same net dollars as philanthropy. Instead of balancing the complementary relationship between love and need, we climb across to the other side of the seesaw. There is nothing (or no one) weighing in on the emotional and spiritual impact of making a gift. With so much pressure bearing down on the fiscal side of the fulcrum, even Archimedes would have a tough time leveraging a donation.

To get our donors back to that place "where love and need are one," we need to do a better job of building connections that do not depend on our hospitals' financial need. It's not easy to do: we

have used the financial argument for so long, and it has worked so well, that it has become a default interaction between fundraisers and donors. And, to be sure, there's always going to be a cohort of donors who will want to know the numbers before making a gift. We should not deny that to them. The point is not to disregard financial need; the point is that if we make financial need the primary criterion for charitable giving, we will lose those donors whenever they believe that there is no need.

RESULTS, NOT RATIOS

In 2013, leaders of the three major national organizations that rate the performance of charitable organizations — the Better Business Bureau's Wise Giving Alliance, Charity Navigator, and Guidestar — took the unprecedented step of publishing two open letters, one to America's donors and the other to America's nonprofits. Addressing "The Overhead Myth," the letters were a call to reject financial ratios as the sole benchmark of a nonprofit's performance.⁴ The concern was that donors who choose to not support a charity on the basis of the charity's overhead may be overlooking the charity's real costs of achieving results.

Charities should not disregard financial metrics of cost and productivity, but they should augment the metrics with evidence of the material impact philanthropy is having.

The national organizations were talking about fundraising productivity, not hospital profitability, but their emphasis on showing results nev-

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ertheless is a point well taken for those of us in Catholic health care. A generous donor once told me that he didn't want his gifts to be used to fund operating expenses; instead, he wanted to make sure that the hospital continued to provide charity care. The irony of his statement was not lost

on either of us. Funding for charity care is nothing if it's not paying for operating expenses, but the emotional resonance of the two purposes could not be more dissimilar. "Operating expenses" is the language of financial need, but "charity care" speaks to the desired outcome and activates the donor's personal connection to the hospital's mission.

DESIRE TO DO GOOD

In restoring the complementary interaction between love and need, I'm not suggesting that we play semantic games with our donors. This isn't a head fake to divert the donor's attention from the hospital's financial statements. This needs to be a meaningful and purposeful approach to soliciting support on the basis of something stronger than money. It goes to the fundamental nature of what it means to make a gift.

At the transactional level, the act of making an online purchase is functionally identical to making an online contribution. But anyone who has done both understands the essential difference between the two. The gift transaction is not happening in a digital, credit-card clearinghouse: it is happening *within the donor*. It happens not simply because the donor is compelled by the beneficiary's financial exigencies, but because the donor is compelled by the desire to do good.

Ultimately, it is this need that matters most. Greater than the hospital's financial need, or the community's need for health care services, is the donor's need to contribute to something bigger than herself or himself. When you look at it that way, the "love/need" dynamic gets flipped. Philanthropy isn't only about matching a donor's love for the institution with the institution's need for financial support; it's also about the institution's love — i.e., our mission — and the donor's need to

be an integral part of that mission.

As faith-based health care institutions, we have a singular appreciation of that place "where love and need are one." In Frost's words, the work of our healing ministries truly is "play for mortal stakes."

It is easy these days to be swallowed up by the massive U.S. health care apparatus, with all of its financial complexity and clinical brilliance, and forget the entirely human dimensions of what we do. Philanthropy has to be more than just another way of paying the hospital's bills. When we fundraisers do our work, we are doing more than simply securing resources for capital projects, medical equipment or charity care. We are connecting our donors with their own best instincts. In asking them to give their means to us, we are giving them the means to fulfill their own basic needs.

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NOTES

1. Robert Frost, "Two Tramps in Mud Time," *A Further Range* (New York: Henry Holt & Co., 1937).
2. Charles E. Zech, *Why Catholics Don't Give...And What Can Be Done About It*. (Huntington, Indiana: Our Sunday Visitor Publishing, 2006).
3. Brian Starks and Christian Smith, *Unleashing Catholic Generosity: Explaining the Catholic Giving Gap in the United States* (South Bend, Indiana: University of Notre Dame, 2013). https://icl.nd.edu/assets/96494/unleashing_catholic_generosity.pdf%22%3Eunleashing_catholic_generosity.pdf.
4. Better Business Bureau, Charity Navigator, Guidestar. *The Overhead Myth*. June 2013. <http://overheadmyth.com>.

QUESTIONS FOR DISCUSSION

Dan McCormack is concerned that fundraisers for Catholic nonprofits have relied too heavily on the financial needs of their institutions and not enough focus has been directed to the mission of the very human aspects of health care.

- What are examples of how your ministry has done a good job of matching the generosity of donors with specific projects dear to their hearts?
- How can your ministry balance its positive financial performance with its opportunities for donors to really feel part of the mission?
- Discuss your ministry's branding and other messaging in terms of how individual donors can relate to its mission, margin and presence in the local and national community.

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