

# US healthcare philanthropy - An examination of best practice and its application to NHS fundraising

## 1. Introduction

This report provides a reflective account of the key findings from research into healthcare philanthropy in the United States. The research was conducted with her counterparts (together with their fundraising teams) within five organisations in the New York and New Jersey areas that represented a diverse range of health systems:

Large city hospital	New York Presbyterian & University Hospital of Columbia & Cornell (NYP) Jay Angeletti, Director of Development
Large regional hospital	Morristown Memorial Health Foundation (MMHF) Jim Quinn, Chief Development Officer
Mid-sized community/ regional hospital	Somerset Medical Centre Foundation (SMC) David Flood, President Regional President of the Association of Healthcare Philanthropy
Large research hospital	Robert Wood Johnson University Hospital Foundation (RWJ) Bruce Newmann, Senior Vice President
Community health system	Meridian Health Affiliated Foundations (MHAF) Dr Michael Luck, President

The objective was to investigate how healthcare fundraising in the US differs from that in the UK, to examine whether their strategies and practices are appropriate to be applied to UK hospital fundraising and, more specifically, North Bristol NHS Trust so as to support innovative approaches to fundraising, increased income and potentially address the difficulties associated with NHS fundraising in the UK. The research was conducted within a small geographical area and may not be indicative of all US healthcare philanthropy. This report aims to provide a reflective account of the learning; asking questions of UK healthcare fundraisers as a starting point for discussion.

The trip was funded by the Allan Brooking Travel Fellowship and this report will be provided to their board, North Bristol NHS Trust, Institute of Fundraising (including their Healthcare Fundraisers Special Interest Group) and the Association of Hospital Charities. The findings will also form the basis of a feature within Professional Fundraising magazine.

Many of the findings highlight successful fundraising activities or approaches that may already be established in many NHS charities and fundraising departments here at home in the UK. With NHS fundraisers facing significant challenges and obstacles it is hoped that this report may enable us to learn from the practices in the US or at least give us the opportunity to look afresh at these challenges and stimulate discussions which may lead us towards solutions.

## 2. NHS fundraising

Fundraising in the NHS is certainly a challenge. Overshadowing all NHS fundraising is the strong prejudice that the Government should be solely responsible for funding the service. In the eyes of the public boundaries have been blurred between what the NHS should fund and what charitable funds should legitimately pay for. The Charity Commission made some attempt to clarify this but was unable to reach an adequate conclusion. NHS Trusts must therefore select only those projects for fundraising that clearly deliver benefits that are over and above what the NHS can provide. There is also much scope for fundraising departments to significantly improve communications to demonstrate how their projects provide this added value. In a charity sector where trends indicate that donors demand more engagement with the charities they support, we in NHS fundraising are under pressure to learn more about our donors' perceptions, motivations and needs if we are to maximise success.

However, a new era in high-level donors are challenging traditional prejudices that Government should provide all social care, education and health care and that any private funding would let them "off the hook". Recognising that Government resources are finite, they are defining new roles for private donations (which are more able than Government to accept risk) within public services. New Philanthropy Capital, a charity that advises donors and funders on how to give more effectively, has highlighted various ways private donations can augment public service delivery. These include testing and promoting innovative approaches to care and subsidising a higher level of care than the Government provides.

Healthcare fundraising in the UK is a growing yet still relatively new area in the charity sector. Some NHS Trusts are significantly ahead of the game (e.g. Great Ormond Street Hospital Children's Charity consistently raises £24m per annum) but sadly other Trusts lag behind with a primarily reactive approach to fundraising. This, together with the difficulties associated with raising money for the NHS, has meant that income generation may be far from maximised. With healthcare charities representing the most popular causes, further research into best practice is desperately needed. The Institute of Fundraising's Hospital Fundraisers Special Interest Group and Association of Hospital Charities are however making huge contributions into promoting the highest standards of fundraising practice in the healthcare sector.

The tactical approach of fundraising within other NHS Trusts is diverse; the most successful spreading techniques across a wide range of income streams with an emerging focus on developing predictable and long-term value from donors. There is a move towards investment in legacy fundraising, major gift fundraising, direct marketing and donor development in the most advanced Trusts. Where major gift fundraising is most successful, there is also the strong commitment and direct support from Trustees (who are commonly the Trust Board acting as a corporate trustee body) and dedicated resources to invest (e.g. Moorfields Eye Hospital raised £10m through engagement of the Trust Board and prospects gleaned from their own contacts). However, commonly there is little active support given to fundraising by Trustees as traditionally their priority is healthcare and financial effectiveness – although its not a big leap to understand how fundraising will support the advancement of both. The NHS charitable funds have traditionally relied upon legacy income but little has been done to invest in proactive legacy fundraising – with the support of the Legacy Promotion Campaign this is beginning to happen in earnest.

Community and events fundraising continues to form the grounding for many successful appeals with this opening many opportunities in the local networks for corporate, major gifts, regular giving and, of course, legacies in the long-term. This foundation in community and events fundraising also contributes significantly to the NHS as a whole through PR and building positive relationships with the local community and networks. Some difficulties are being experienced as the trend continues within charitable trusts towards an ineligibility for NHS projects.

There is a slow move towards new media with some larger appeals employing DRTV, text donations as well as the more established online giving. Direct marketing is a rapidly growing area of NHS fundraising and, whilst bringing data protection issues, holds great potential for income generation within the NHS as the warm target audience (patients) is considerable (e.g. remarkable success was achieved within King's College Hospital with an average gift of £188 and a 5.5% response rate). As the need for a higher ROI and predictability of income increases within the charity sector many NHS Trusts are moving towards setting up membership, lotteries and regular giving programmes to enable greater flexibility and responsiveness to urgent funding needs, such as for medical equipment.

### 3. Governance of US healthcare philanthropy

The majority of fundraising within the US healthcare system is governed through a separate organisation (usually called a Foundation) and not within the hospital. The formation of affiliated Foundations began in the Western regions of the US more than 25 years ago and has gradually moved East. This move was made to ensure absolute accountability and transparency – it has ensured that donors feel more comfortable when giving to an organisation with solely charitable purposes and its own board of Trustees who are responsible for raising and distributing funds. There is little or no overlap in membership between the hospital boards and Foundation boards within US hospitals - however fundraising is absolutely integral to the hospital's strategic direction and activities (Association for Healthcare Philanthropy – GI Poll).

The only exception within the group of hospitals involved in this research was NYP. This development department was governed in a similar way to the Corporate Trustee Bodies that govern the majority of the UK's NHS charitable activities. Their department is part of the healthcare organisation with its Board also taking on the responsibility as Trustees of the charity).

With accountability and transparency being just as important within our own system and the difficulties presented by the public's attitude to NHS fundraising, should our NHS be looking towards other forms of governance outside our own Trust Board as the Corporate Trustee Body? The immense success of the NYP is however notable with them raising far more than any other hospital visited. Whilst this may be clearly attributable to their location in New York City it may suggest that problems associated with governance by a corporate trustee body are not insurmountable.

### 4. A culture of giving in the United States

#### **Attitudes to money**

A striking difference in national culture exists. Philanthropy is a proud and established tradition in the US. Charitable giving far exceeds that in the UK with Americans donating 1.8% of Gross Domestic Product compared with 0.7% in the UK. People in the US are far from bashful when discussing money – especially in New York City. This has led to a strong culture of giving throughout the US – not least in healthcare fundraising. Fundraising within New York City is transactional, business like and very open. There are expectations that people will give and at a certain level; this has naturally increased the average size of major gifts and the number of donors. Wealthy altruists are not bashful about telling their friends that they should also give. Similarly, donors expect visibility and recognition. This direct and confident approach is also true with the US fundraiser's approach to making "the ask".

Comparatively, we in the UK can be reserved when discussing salary and charitable donations and similarly UK fundraisers across the charity sector can be uncomfortable in the solicitation of major gifts. For a nation where it is considered rude to talk about money and worse still to ask for it, major gifts fundraising is still in its infancy. Many UK fundraisers avoid making "the ask" and many of us struggle to resist the urge to break the excruciating silence with polite chat after we have asked for that big gift. To change our whole country's culture may be a tall order but do we need to take a leaf out of the US fundraiser's books and become bolder and more direct in asking for that major gift?

#### **Attitudes to healthcare fundraising**

Whilst the US healthcare system is privately financed rather than Government run, they face similar difficulties to NHS fundraisers – some people may feel that they already pay enough through their insurance premiums. They tackle this argument head on and thus do not find this attitude dramatically affects fundraising success. US healthcare fundraisers vehemently argue that there is not an example of a premier institution (whether healthcare or university) in the world where that reputation has been achieved without significant philanthropy. Insurance premiums provide a service at an acceptable level but it has become widely recognised that, with fundraising, they will receive a first class service. Are we as UK healthcare fundraisers too reactive and reserved - ready with Q&A's but not aspiring to change public attitudes or challenge the ineligibility guidelines of grant-making organisations?

Healthcare philanthropy in the US is well established and has had a professional fundraising approach for many years before it developed in the UK; representing 8.7% of total US giving (Giving USA 2004). Many hospitals were founded on donations and have been actively fundraising for decades; it is not a "side show" but part of the fabric of the organisation. They do not apologise for the need for fundraising – it is an accepted and proud tradition. With healthcare becoming increasingly expensive in the US and with more and more individuals uninsured, fundraising is becoming imperative and accepted to keep the service at the leading edge.

Do UK healthcare fundraisers need to take the bold step to collaborate to work to change attitudes to NHS fundraising? The Institute of Fundraising's Healthcare Fundraiser's Special Interest Group may present the ideal mechanism for us to work together to develop a robust case that tackles negative attitudes and establishes a strong trust and confidence in our work.

### **Tax benefits**

A large factor in this pervasive culture of giving is the significant tax benefits for donors; particularly supportive for higher level giving. A donation can become a very effective tax planning strategy with structured planned gifts helping donors avoid a substantial reduction in their estate from capital gains, estate and gift taxes. Income from charitable Gift Annuity programmes can help transform low yielding investments into an increased source of income for donors. These wide reaching benefits have created an environment in which giving at a significant level is the norm.

The UK is lucky to benefit from the Gift Aid scheme, but how much do donors and, more importantly, fundraisers know about other methods of tax efficient giving in this country? The benefits on offer to UK higher rate tax payers are less well known and, surprisingly, not promoted as heavily as Gift Aid. The Institute of Fundraising's promotion of tax effective giving will go some way to addressing this situation but we, as fundraisers, have a responsibility to expand our knowledge of tax efficient giving and communicate these advantages to our prospects and donors. Furthermore, how can UK fundraisers influence the Government to further improve tax advantages to encourage a culture of giving that rivals that seen in the US? US healthcare fundraisers use tax benefits to their full advantage offering a vast range of giving options to their donors to make it personally advantageous and easy to give.

## **5. A culture of giving in the hospitals**

This strong culture of giving in the US is powerfully evident within each hospital. There is a strong pride felt towards the healthcare system that is skilfully harnessed to inspire and celebrate philanthropic support. There is significant investment in marketing to ensure each hospital can maintain their competitive edge (a move which is beginning in earnest in the UK as we move towards the new "Choose and Book" system) and successfully enthuse a tremendous feeling of pride and ownership in the achievements of the hospital within their community. This was most evident in NYP where fundraising's message seemed to pervade each and every marketing material and the Annual Report became an inspirational book that celebrated the achievements of the hospital and how philanthropic activity has made it a first class organisation. The hospital management recognise that philanthropy can play a crucial role in achieving the mission of the organisation when every element of the organisation works in partnership with the development office.

Development staff work with the CEO to instil an attitude and environment within the organisation that values and is conducive to philanthropy. They firmly promote that all staff, regardless of rank or role, should understand their responsibility for promoting philanthropy within the organisation. It is clear that fundraising is no mere tag on – it is an integral part of the strategic direction and vision of each hospital and an impressive effort has been made to ensure that each and every opportunity is taken to promote philanthropy. The result - a hospital and cause that you simply believe in and feel an urgency to support. Can we, in the UK, create a similar environment within our hospitals? Whilst fundraising is important to our respective NHS Trusts, are our fundraising strategies central to the Trust's overall strategic direction?

The mission of each Foundation/development department not only states what they aim to achieve but also reflects and supports a culture of giving. MMHF's mission is "to inspire community philanthropy to advance exceptional healthcare for patients". To be driven by a mission of inspiring giving must surely drive the creation of a culture that is supportive of the most successful fundraising.

**Donor relations and recognition**

Donor recognition saturates each hospital site creating an unmistakable visible presence of fundraising and ultimately supporting the creation of a culture of giving. Donor recognition predominantly takes the form of honour roles on commemorative plates and signage as well as a plethora of naming. Almost every sign for every room has recognition for the sponsor included – plaques even appeared in lifts! Naming is widespread – Jim Quinn from MMHF aptly believes “if it doesn’t move, we name it!”

The use of honour roles was considerable and very grand, requiring significant investment and even included engraved marble (see right – recognition above a door arch in NYP). These are used to thank donors but, more importantly, to highlight the levels of gift as well as those who have not given. During special campaigns these roles are updated quarterly to encourage new and regular gifts so new names will appear in the next period.

The information provided on these honour roles is explicit with levels of gift advertised (see below – benefactor wall in NYP) to encourage peers to give at the same or higher level, increasing the average size of major gifts. Honour roles range from the very grand tablets through to supporter newsletters which commonly include page after page of donor names.



Their focus on donor relations recognises that successful fundraising is about more than just money but about relationships. Their meticulously planned approach to stewardship may include tour nights for high value donors, appreciation and cultivation receptions, distinguished donor programmes (those that have given \$5k+ receive special treatment should they become a patient – daily newspapers, flowers etc) through to personal thank you calls for every new donor, tiered levels of thank you letters (with the highest levels donors receiving personal letters from the CEO/natural partners and graded listing of every single donor and their gift in newsletters.

Such is the importance of donor recognition, a Stewardship Committee oversees MMHF's donor stewardship and recognition programme, ensures that donors are recognised appropriately and cost effectively in relation to the level of their gift and that donors are kept informed about the use of their gifts and hospital news. The committee is also responsible for evaluating the effectiveness of recognition and stewardship in donor development. With the significant income targets and high workloads expected of UK and US professional fundraisers alike, it is all too easy to lose focus on donor relations activities but investment in tiered recognition packages such as these can significantly increase the long term value of our donors.

**Fig. 1: Example of a tiered donor relations programme (MMH)**

- 1892 Founders Society (Gift Club Programme)
- Annual Chairman's Dinner (individual/organisational donors who give \$2,500+)
- Annual Jefferson Associates Reception (\$1,000 - \$2,499)
- Brookfield Society newsletter, programme and annual luncheon (planned gift donors)
- Courtesy Plus Programme (major and planned gift benefactors who are hospitalised)
- Founders wall (individual/organisational donors who give \$1,000+)

There are some original approaches to donor recognition through each of the hospitals which move beyond than the traditional plaque. MMHF have recently unveiled a Donor Wall in reception (pictured right) which is centred on the theme "behind every gift is a story" and periodically spotlights a new series of donors who tell us in their own words what inspired their philanthropy. The wall includes a simply stunning stone engraved tablet with a running waterfall creating a feeling of calm and inspiration.

Donor recognition is used on a massive scale and is supported by comprehensive approaches to donor relations. Together they provide donors and potential donors with a strong and lasting involvement in the hospital and have made a huge contribution to creating the culture of giving that pervades the US and each of the hospitals visited.



## **Trustees**

Without exception, the US healthcare fundraisers have the active support of their Trustees. These individuals gave significant financial contributions as well as help in networking, cultivation of prospects and solicitation of gifts. Some also chaired committees which led specific campaigns. They feel a responsibility to be involved. In one organisation nearly 100% of major gift income had been achieved through Trustee networks. Within MMHF more than 20% of their total income were personal Trustee gifts – indeed, the Trustees (together with the employees) pledged to raise \$16m towards a total \$44m target for their new heart hospital.

It could be argued that four of the five hospitals visited were Foundations where Trustees had the sole responsibility for governing charitable activities and therefore recognised their responsibility in supporting fundraising. Can this support then be expected from our Corporate Trustee Bodies in the NHS? NHS fundraisers may argue we should – particularly from non-executive directors who often have strong links into the community's social and business networks. Furthermore, the incredible scale of success at NYP which has a similar governance structure to the majority of NHS Trusts suggests we should. Here, board members do not join the hospital unless they are prepared to make a significant gift and support the fundraisers. They are asked to make the organisations' fundraising their philanthropic priority. The challenge for UK healthcare fundraisers is to work closely with our CEO's to create a similar culture with our own Trust Boards? The Association for Healthcare Philanthropy has recently made suggestions to further improve the Trustee/fundraising relationship, which are just as relevant for NHS fundraisers:

- Joint participation in the development of the Foundation's strategic mission and vision.
- Clear job description for board members which give clear expectations.
- Clear, open, honest, frequent, high-quality and meaningful communication.
- Mutual respect (inspiring trust and confidence).
- Both the Board and development staff must focus on what is good for patients, the community and what is attractive to donor partners.

But the Trustee involvement achieved in US healthcare fundraising is not coincidental; they need to be inspired for not all Board members are actively involved. Fundraisers are earnest and persistent; suggesting that they all want to move the organisation forward and fundraising is the perfect way to achieve that. SMC encourage their Trustees to complete an annual self-evaluation as well as sign an annual affirmation of service to remind and encourage them in their responsibility for fundraising. They also recognise that they cannot expect Trustee help in prospect identification and solicitation of gifts without their strong guidance and support; recognising that these individuals are not professional fundraisers and may not know how best to ask someone for a donation.

## **Head of the hospital**

Hospital CEO's are devoting an increasing amount of time to fundraising with a more recent dramatic increase in fundraising responsibilities by 59% in the past three years (Association for Healthcare Philanthropy – GI Poll). The active support and involvement of the head of the hospital in fundraising is consistently argued to be the single most important contributor to the huge success in US philanthropy. They are the driving force for fundraising in the most successful hospitals. It has become common for these individuals to make fundraising one of their top five priorities believing that, if they don't, philanthropy will never matter to anyone else. Increasingly CEO's are even selected on the basis of their experience in fundraising. Despite the majority of healthcare fundraising is governed by separate Foundations (and therefore a separate Board of Trustees), fundraising is viewed as an equal priority as the leadership of the hospital, an integral part of the organisation's strategic direction and the head of the hospital is energetically involved in fundraising - creating a natural internal culture of giving.

It appears the norm that the development team have a regular meeting arranged with the head of the hospital (usually fortnightly or monthly) to which they can invite prospects for breakfast/lunch to discuss the impact of their potential philanthropy. Should these slots not be filled they are released one week before. The head of the hospital is widely involved in such stewardship activities; prospects are flattered to be invited to meet this notable individual and are more likely to give a significant gift. MMHF have found that they can fill their fortnightly slots with the Head of their hospital ten times over. The most significant support from a head of a hospital was found in NYP where they dedicated nearly half their time to development activities and delegated operational duties to a deputy. UK healthcare fundraising would surely benefit from a similar level of engagement from our Chief Executives and Chairs – the challenge remains as to how to establish a commitment to such time consuming involvement from our senior colleagues.

## Employees

The majority of healthcare fundraisers in the US have made great strides in engaging with the employees of their organisation believing they cannot expect others to give if their own staff do not. There is a significant investment in planned employee involvement programmes which bring far reaching benefits to the whole organisation as well as increased fundraising income. These programmes include free employee raffles (for active donors only), Pie Day (where senior management give away pies to active donors), lists of employee donors erected monthly on honour roles (including levels of gift), awards, promotion of significant support in hospital newsletters and the recruitment of well respected employees as ambassadors/champions to communicate the case for support to other staff, patients and families.

Their resolution to further develop the already significant employee support is impressive; David Flood of SMC joked – we get them to give \$1 and then thank them to death! This Foundation has an Employee Campaign Committee, run by no fewer than 64 volunteers. These members of staff are committed ambassadors for the development team and actively encourage giving through the peer to peer ask. Other hospital systems recruit volunteer employee champions from each department that are committed to fundraising and lead the effort, collaborating to identify common goals and serving as advocates of the process, especially with regard to the impact of philanthropy on their own operation.

Some have faced similar problems with limited staff support for fundraising as many NHS Trusts do in the UK. The benefits of this planned approach are evident – especially within the more regional and community hospitals. Employee fundraising represents a significant income stream in isolation. In the hospitals that were visited, the culture of giving is so engrained that it is expected that the physicians make a significant donation each year. NYP expect their higher earners (over \$500k) in the organisation to become committed givers - pledging 10% of their salary over five years. There is still some way to go to achieve the active support of all staff but there is an established appreciation of the importance and value of fundraising. Such appreciation is incredibly important for these individuals are ideally placed to promote the case for support to patients and their families – they can be more powerful than any professional fundraiser. Indeed, a striking observation was that almost every member of staff that passed by during tours of each hospital knew each of the fundraisers by name – perhaps an aspiration that every UK NHS fundraiser should have.

One hospital (MMAF) has taken employee involvement further. They recognise that retired, long service physicians are the hospital's best friends; they feel strongly about the hospital, know the organisation best, understand the needs of the hospital and where money will make a difference. These iconic figures are being recruited as volunteer major gift fundraisers, asking them to network with their colleagues to secure large gifts and reimbursing their travel and entertainment expenses.

Many hospitals are taking a planned approach to educating and engaging staff in philanthropy by promoting participation in new employee orientation sessions, developing training sessions with role-playing for nursing staff and providing information on how to make grateful patient referrals to the development staff. Some have developed "Partners in Philanthropy" programmes which highlight and honour successful grateful patient referrals with awards, articles in staff newsletters and posters around the site. Not only do these activities encourage the strong active support of employees but also increase the visibility of philanthropy throughout the organisation.

Patients have great respect and appreciation for their physicians and these members of staff are an essential link between the patient, the healthcare organisation and the development team. This unique relationship means that it is important to involve physicians in the identification of grateful patients as well as the cultivation and solicitation process. Development staff therefore dedicate a significant amount of time with physicians to build trust, an understanding of philanthropy and their role in the process, including:

- Implementing an education programme for physicians that explains how to refer grateful patients to the development team (in compliance with the patient privacy law HIPAA).
- Creating physician philanthropy advisory committees to develop a toolkit to facilitate physician engagement in the process – such as a "referral prescription pad" so they can write down grateful patients names and easily return referrals to the development team.
- Recruiting physicians to serve on development committees.
- Establishing a recognition programme to highlight physicians who refer patients who become active donors.

The importance of employee involvement is obvious. These individuals can be more powerful than any professional fundraiser. US healthcare fundraisers have made great strides in encouraging employees to remember philanthropy during their day to day jobs when talking to patients and visitors. These individuals are the first point of contact for potential donors; if they are committed to a culture of giving then fundraising will inevitably be a success.

### **Supporting structures**

Some hospitals have set up a plethora of committees/councils to support fundraising that involve employees, Trustees, physicians and individuals from the community. An example of some of the committees that support the work of the fundraisers at MMHF are noted below. NYP have moved towards harnessing the new wealth and drive from young professionals in the city by setting up a society - "New Leaders". This new approach aims to keep the development team at the forefront of major gift fundraising and ahead of their competition by cultivating the new emerging mid to high level prospects.

#### **Fig. 2: MMH fundraising committees**

Brookfield Society Advisory Committee: provides guidance on the administration of the planned giving programme. Helps to identify and approach prospective donors interested in making gifts through their estate plans

Business Committee: Business executives providing guidance and outreach in the solicitation of companies/private firms within the area

Foundation Advisory Council: Volunteers with access to private foundations provide outreach to local and national foundations that support healthcare

Jefferson Society Committee: Seeks gifts of \$1,000 - \$4,900 a year from former patients and community residents

Major Gifts Committee: Seeks gifts of \$5,000 or more from former patients and community residents

Oncology Philanthropic Leadership Council: Seeks gifts of \$5,000 or more specifically for the cancer centre to support capital improvements, service development and clinical research

Paediatric Philanthropic Leadership Council: Seeks gifts of \$5,000 or more specifically for the children's hospital to support capital improvements, service development and clinical research

## 6. Income and expenditure

The summary below presents a snapshot of the financial information from each organisation. The phenomenal income received by NYP reflects a unique sales like approach to major gifts fundraising that is suited to New York City. This formula may not apply so easily to the community or regional hospitals in the US or indeed in the NHS in the UK. Their success however is impressive – they launched a \$1bn campaign in 2000 and reached the target three years ahead of schedule in 2007.

**Fig. 3: Financial comparison**

	Income 2006/07 (\$)	Expenditure 2006/07 (\$)	Cost income ratio (%)	Broad income streams %
New York Presbyterian & University Hospital of Columbia and Cornell	200,000,000	10,000,000	5	Corporate 5% Trust/foundations 5% Individuals 90%
Morristown Memorial Health Foundation	18,000,000	3,600,000	20	Corporate 7.5% Trust/foundations 7.5% Individuals 85%
Somerset Medical Centre Foundation	8,500,000	1,780,000	21	Corporate 6% Trust/foundations 10% Individuals 84%
Robert Wood Johnson University Hospital Foundation	4,000,000	805,000	20	Corporate 25% Trust/foundations 15% Individuals 60%
Meridian Health Affiliated Foundations	24,000,000	5,420,000	13	Corporate 10% Trust/foundations 10% Individuals 80%

Cost income ratios are perhaps similar to those within many NHS fundraising departments although the lower ratios reflect the balance in fundraising techniques employed – with a significant and almost exclusive focus on major gifts fundraising. A general benchmark provided by the Association for Healthcare Philanthropy is 20-25% cost income ratio. Please note that some expenditure stated may include solely direct fundraising costs whereas others may also include non direct costs such as rent and utilities.

Across the United States there is a consistent focus and success in major gift fundraising in healthcare with more than 60% of all donations being more than \$1m (Association for Healthcare Philanthropy – GI Poll):

Less than \$1 million	39%
\$1 - \$5 million	36%
\$6 - \$10 million	8%
\$11 - \$20 million	7%
\$21 - \$30 million	2%
\$30+ million	3%

Healthcare fundraising has seen dramatic growth in recent years. Charitable contributions to healthcare organisations in the US increased by a record 16% to \$7.01 billion in 2005 (Association for Healthcare Philanthropy – Report on Giving) and have doubled in the last four decades.

The percentage split in income streams illustrated above roughly aligns with US healthcare philanthropy trends which has seen 60% of income raised from individuals, 18.2% from businesses and corporate foundations, 12.7% from other foundations and the remaining 9.9% from other sources (such as hospital auxiliaries, public agencies and civic groups). Individuals represented 83.7% of donors and businesses, including corporate foundations, were 10.9% of the donors. Employees who were non-physicians represented 18.9% of the individual donors; the next largest group was patients at 16.5% followed by physicians (5.5%) and trustees (4.9%) (Association for Healthcare Philanthropy – Report on Giving).

## 7. Fundraising best practice

### **Income streams**

The most significant and successful income stream in US healthcare fundraising is major gifts which steals the focus of the majority of fundraising activity. Some of the most successful techniques in major gift fundraising have only been possible because of the establishment of a strong culture of giving within the organisation. This culture has allowed for the implementation of major donor programmes necessitating a supportive processes and significant senior management involvement.

The key to the majority of fundraising strategies is to engage with the "grateful patient"; a move often avoided within the NHS for fear of infringement of data protection legislation and ethical boundaries. The Association for Healthcare Philanthropy notes that the most successful healthcare development organisations share a common element – the presence of effective strategies for identifying and cultivating grateful patients. The most effective strategies, they say, depend upon internal factors such as creating a culture of philanthropy, providing educational and training programmes for staff and physicians to encourage their active involvement. The development teams recognise that they must strategically enrich the relationships between the grateful patient and the hospital through personal visits, tours of the facilities, volunteer opportunities and other cultivation activities and events – all major gift strategies focus very specifically on relationship building activities that engage and involve the prospect in the mission of the hospital.

One such approach was implemented at MMHF after research demonstrated that more than 500 major gift prospects were coming through the hospital as patients every year. The development team now screen the patients exit lists at the end of every month and identify around 40 prospects which are graded according to propensity to give (A=\$1m, B=\$500k, C=\$250k, D=\$100k). They immediately begin their relationship building process recognising that they may be more likely to give the sooner after the experience they are asked. 30-45 days after these individuals leave hospital they receive a letter to introduce the Foundation and give them a free parking permit. During the next two weeks the prospects are called by a "natural partner" (e.g. head of the hospital, Trustee, peer, physician, department head or donor relations manager should there not be a natural partner) who will discuss their patient experience and explore whether they have a specific area of philanthropic interest. The relationship building activities continue with an invitation to visit for tour and discussions about a project which will fit their needs. A number of other well planned cultivation activities may follow and then the natural partner will make the ask at the appropriate time. MMHF find that 15-18% of prospects agree to a tour or interview and, of these, around 40% agree to a gift – evidence enough that screening patient exit lists is a simply yet effective approach. The challenge here in the UK will be to look carefully at the data protection legislation and gain senior level commitment within our NHS Trust to this potentially controversial approach.

The approach to fundraising within the NYP is unique and perhaps most suited to the New York City culture. With their 150 strong "sales force" of fundraisers they have a business approach to generating income. They have targets and guidelines regarding how many calls to make to prospects and debrief forms to complete after every call. They aim to set up a briefing meeting with prospects where they introduce their work, followed by stewardship calls and finally a solicitation meeting when they will ask for the gift. This illustration is somewhat simplified but it is perhaps closer to a hard sales environment than any other fundraising department in the world – are NHS fundraisers and the UK charity sector as a whole ready to be that bold?!

A key element of the major gift relationship in RWJ is the extended family. They have a great awareness of the donor's whole family unit and understand that their respective support is essential, as the donation decision may involve and ultimately affect them. The donor's family are therefore involved throughout the cultivation process to ensure commitment. This not only pre-empts any potential reversal of the decision to donate but also "carries the torch of generational support" encouraging the donor's offspring to continue their tradition of giving after they die. Perhaps the ultimate legacy?

Many hospitals promote tribute giving programmes which provide the opportunity for their donation to be recognised as an expression of thanks, good wishes or remembrance. MHAF run a Tribute Programme which encourages Honour Gifts and Memorial Gifts. Honour Gifts are given to honour a birthday/anniversary, as good wishes for someone who is ill, in recognition of outstanding staff or care. Memorial Gifts are given in remembrance of someone who has passed away or as an expression of sympathy to family and friends. All Tribute Gifts are inscribed within the Commemorative Register (elegantly described as "a handsome, leather-bound volume" on display in the main reception and the individual/family named by the donor will receive a special card acknowledging the gift has been made in their honour. Whilst in memoriam gifts may be regularly received by many NHS hospitals in the UK, rarely do we employ as a proactive an approach in their solicitation and recognition as witnessed in the US.

There is, however, significantly less community and events fundraising within US healthcare philanthropy than in the NHS although this is more evident and a proud achievement within some of the smaller community hospitals such as SMC. Generally the aims of events are primarily donor cultivation and recognition and not financial; a means of meeting with people to develop them in to committed and higher level donors – they are informative, educational and engaging. Some have a huge budget – with NYP spending \$1m on one reception for major donors.

It is generally thought to be ideal if a hospital's fundraising mix is as wide as possible to foster philanthropy at all levels – from events, direct marketing, annual giving programmes, grants, corporate, planned giving through to major donors. There seems to be a trend towards investment in new or expanded programmes of fundraising within UK healthcare. Without exception however, income streams are heavily weighted towards major gifts (including individuals, corporate and charitable trusts) with a large proportion of this income from individuals. Major gifts fundraising is still comparatively new within the UK charity sector, not least within NHS fundraising. We may have much to learn from their successful approach to major gifts but must not lose sight of the huge achievements within in community and events fundraising as well as PR/media and celebrity involvement. Investment in such income streams and activities path the way to committed/planned giving, major gifts and legacies as we develop our donors as well as providing links into trusts and corporate income. Community and events fundraising can provide the strongest platform and foundation for strategic fundraising success.

### **Donor development and planned giving**

The focus on donor development continues through every single fundraising activity. Telemarketing and direct marketing is commonly used to solicit repeat gifts and convert donors to planned giving. There is a strong focus on providing donor choice with a huge array of different giving options to allow them to develop a gift plan that suits their needs – both personal and philanthropic. Fig 4 illustrates the options open to RWJ donors.

Many of the hospitals in the US run an Annual Giving programme to encourage planned giving on an annual basis; these are encouraged to be unrestricted to support the ongoing financial demands of the organisation. It is paramount that donors have total confidence in the institution to which they give – confidence that the Board of Directors will determine the most effective use of their gift. To build such an unrestricted, regular income in the UK, within a culture that is sceptical of NHS efficiency, the challenge for healthcare fundraisers is to develop powerful relationships with our donors that inspire confidence in our organisations. However, clearly these relationships must be built on a foundation of an accountable and efficient organisation.

**Fig. 4: RWJ donor choice**

<b>Your gift</b>	<b>Your goal</b>	<b>How you make the gift</b>	<b>Your benefits</b>
Bequest	Defer a gift until after your lifetime.	Name us in your will or revocable living trust (designate a specific amount, a percentage or a share of the residue).	Gift exempt from federal estate tax. Control of asset for your lifetime.
Outright gift of cash	Make a quick and easy gift.	Simply write a cheque.	Immediate income tax deduction. Reduction in your taxable estate.
Outright gift of securities	Avoid tax on capital gains.	Contribute long-term appreciated stock or other securities.	Immediate charitable deduction of full fair market value. Avoidance of capital gains tax.
Outright gift of personal property	Share your enjoyment of a collection or other personal item.	Donate tangible personal property used for our tax-exempt function.	Charitable deduction based on the full fair market value.
Gift of life insurance	Make a large gift with little cost to yourself.	Contribute a life insurance policy you no longer need.	Current income tax deduction. Possible future deductions through gifts to pay policy premiums.
Bequest of retirement assets	Avoid the twofold taxation on IRAs or other employee benefit plans.	Name us as the beneficiary of the remainder of the assets after your lifetime.	Make the gift from the most highly taxed assets, leaving more for family. Avoid income and estate tax.
Gift of Individual Retirement Account (IRA) distributions	Take advantage of the limited gift opportunity available through 2007.	Transfer up to \$100,000 in 2007 from your IRA to an eligible organisation (excluding donor advised funds and supporting organisations).	Available only to donors aged 70 ½ or older. Avoids income taxes; no charitable deduction.
Gift of real estate	Make a gift of an asset no longer needed and generate an income tax deduction.	Donate the property to us, or sell it to us at a bargain price.	Immediate income tax deduction. Reduction or elimination of capital gains tax.
Gift of retained real estate	Give your personal residence, holiday home or farm now but continue to live there.	Deed ownership of your home to us but retain occupancy.	Valuable charitable income tax deduction. Lifetime use of residence.
Charitable remainder unitrust	Create a hedge against inflation over the long term and augment your retirement income.	Create a trust that pays a fixed percentage of trust's assets as revalued annually.	Variable income for life. Immediate income tax charitable deduction.
Charitable remainder annuity trust	Secure a fixed income and supplement your retirement funds.	Create a charitable trust that pays you a set income annually.	Fixed payments for life, often at a higher rate of return. Immediate income tax deduction.
Charitable gift annuity	Supplement income with steady payments that are partially tax-free.	Enter a charitable gift annuity contract with us that pays a set amount for one or two lives.	Current and future savings on income taxes. Fixed payments for life.
Charitable lead trust	Reduce gift and estate taxes on assets you pass to children or grandchildren.	Create a charitable trust that pays fixed or variable income to us for a specific term of years; principal is retained for heirs.	Reduces your taxable estate. Property kept by your family, often with reduced gift taxes.

Fundraising in US hospitals have been affected by the new HIPAA (National Standards to Protect the Privacy of Personal Health Information). This data protection law forbids the sorting of patient information into specialty – the development team therefore cannot target direct marketing campaigns to patients from oncology for a new cancer unit campaign but must mail all patients. However, the varying interpretations of HIPAA in hospitals throughout the US have created significant differences in how development offices are permitted to access information about patients – many may not be accessing patient information to the full extent that is permissible under the law. Whilst the NHS Trusts appear uncomfortable with direct marketing for fundraising purposes with regards to data protection, ethics and risk we are able to target specific groups of patients potentially allowing us to achieve a much higher return on investment. However, accessing patient information continues to be a challenge for NHS fundraisers – not least because of the anti-risk culture within which we operate. The scope for fundraising is massive. Imagine how many of our prospects may have passed through our hospitals without our knowledge. These grateful patients are our greatest chance of massive fundraising success. If we can address the ethical concerns of our Trustees, whilst ensuring we adhere to the data protection legalisation, imagine how successful we might be. NHS fundraisers may need a greater understanding as to how the data protection laws related to our work and need to invest in educating our Trustees as to the benefits of engaging with our grateful patients and how this can be achieved in a sensitive and lawful way.

With the increased focus on grateful patients in healthcare philanthropy many hospitals, such as SMC, are developing proactive VIP programmes to provide special attention to select patients whilst they are in hospital. All patients will receive the same high quality medical care but the development team treat these patients as special guests and may offer extra perks such as larger private rooms with family space, special meals and refreshments for family/visitors, personal visits from development staff/hospital leadership, small gifts, blankets, flowers, newspapers delivery, bottles of water, toiletries (including lip balm printed with the hospital logo!), note cards, parking passes, free valet parking, get well cards delivered by development staff, robe with the charity's logo, portable room refrigerator, coffee maker, CD player and CD's. Some programmes even provide a member of the development team to act as a personal assistant for top level donors! An Association for Healthcare Philanthropy survey reported that several hospitals do not allow the development team to be informed when a donor or prospect is in their facility because it may be interpreted as a violation of patient privacy laws. However 73% of respondents to the survey say that they make personal visits to donors and prospects whilst they are patients indicating that different organisations have different interpretations of these laws.

Planned giving in US healthcare encompasses a considerable range of ways of giving including bequests, charitable gift annuities, charitable remainder trust, charitable lead trust, real estate, revocable living trust, transfers from an Individuals Retirement Account and life insurance. Tax-deductible donations of personal or commercial property can offer donors significant tax advantages – they may reduce capital gains taxes, avoid probate costs and save on estate taxes. Benefactors can also make the tax-deductible donation of their home and continue to live in it whilst avoiding the cost of upkeep. Similarly, commercial property owners can donate surplus property to relieve them of the obligations of maintaining an unproductive property and realise significant corporate tax savings. In SMC, their Heritage Circle provides an elite society for planned givers (including those who make a bequest through a will or living trust, set up an income producing gift such as a gift annuity or name the foundation as the beneficiary of a life insurance policy). Circle members then benefit from exclusive invitations to events and seminars, personal tours and listing in publications.

Planned giving, whilst providing the donor with significant tax advantages, is viewed as a way to become a major donor for the mid-value prospects. It is marketed by RWJ to the medium level, regular donors or "loyals" as a means to make a significant donation that they would not think possible. The culture of giving has created an aspiration to become a significant player in philanthropic circles and planned giving provides an ideal mechanism to step up. They examine a range of options to make a number of pledges over a series of years which will equate to a major gift. They work closely with the donor to agree a flexible arrangement which allows them to stay in control and make instalments at a level which suits them each year according to their own investment portfolios. In some hospitals, donors who give through a planned giving programme automatically become a member of a society or club with special donor recognition activities such as invitations to special events.

There is a significant and bold move towards looking at providing the donor with as many choices as possible as to how they can give so that they, as fundraisers, can maximise long term potential. Whilst some of these methods of fundraising may not easily transfer to the UK as we have very different taxation systems, we may ask ourselves how easy we make it for our donors to give and are we providing them with the right options and information to support their decision. Are we, in the UK, making the most of our mid-wealth prospects and donors to help them become major donors through an innovative approach to planned giving?

**Fig. 5: Example of a planned giving clubs (RWJ):**

The Friends Club (\$25-\$99): Listing in the Foundation's Annual Report and special mailings throughout the year  
The Century Club (\$100-\$499): All of the above plus invitations to special events  
The Tower Club (\$500-\$999): All of the above plus annual briefing dinner with the hospital President  
The President's Club (\$1,000-\$4,999): All of the above plus 2"x3" recognition engraving on the History of Caring sculpture  
The Chairman's Club (\$5,000-\$9,999): All of the above plus 3"x6" recognition engraving on the History of Caring sculpture  
The Robert Wood Johnson Club (\$10,000+): All of the above plus 4"x6" recognition engraving on History of Caring sculpture

At the heart of all fundraising activities in US healthcare fundraising is the donor. Donor relations, donor development and donor recognition are terms used daily in the world of fundraising and there are some fine examples in the UK charity sector and in NHS fundraising. But US healthcare fundraisers invest heavily and implement them with excellence.

A similar approach to planned giving and donor choice may well be common practice within the major gifts departments of some of the UK's larger charities and possibly the larger NHS fundraising departments but it can be just as effectively implemented across all NHS Trusts and indeed other smaller charities. We need only view the world through the donor's eyes and provide ways of giving that meet their needs and desires.

**Brand**

In a culture where the power of the brand was born, US healthcare charities seem to operate under the name of the foundation rather than establish a separate name, logo or brand identity like many NHS trusts have chosen to do – e.g. the Forever Friends Appeal at the Royal United Hospital Bath. Perhaps the culture of giving and the powerful trust felt towards these Foundations in the US makes a brand comparatively meaningless. The Foundation's name has become a powerful brand in its own right – becoming a powerful symbol of their mission, vision and values and instilling a confidence and trust in the organisation. Interestingly, an exception was the NYP (a development department that governed by the hospital and not a separate Foundation) that operates under the banner "To Realise Medicine's Promise – The Campaign for New York-Presbyterian". Some hospitals have begun to develop branding to support specific capital appeals - SMC launched their first branded appeal "Breaking New Ground" to support a major expansion and modernisation project throughout the hospital.

There seems to be a split in the UK; some NHS Trusts brand capital or long-term charitable appeals whereas the majority of NHS fundraising operates under the name of the hospital or charitable fund. The latter may hold great weight within well known and respected hospitals or those with significant existing community support but investment in a brand can bring far reaching benefits in developing public trust, recognition as well as supporting the recruitment of new and development of existing donors. Perhaps a greater focus on the development of our brand may go some way towards developing a similar level of recognition, confidence and trust as that established by our US counterparts – particularly within NHS Trusts that may have experienced more challenging PR issues such as large financial deficits.

## 8. Projects

There is a strong donor centric rather than a project led approach to fundraising. Whilst many US hospitals chose large projects to form campaigns around, they all employed an intelligent approach to forming projects around donor interests and philanthropic desires. An interesting analogy from MHAF encapsulates this concept:

*Fundraising in our hospital is like visiting an exclusive restaurant. Your waiter brings you your menu and tells you of some of the specials on offer that evening (e.g. new children's hospital, new cancer centre). They may then tell you that if you would like anything that you don't see on the menu, they can ask the chef and they can put it together for you.*

This goes beyond the usual project led approach to fundraising seen widely in the UK (which just identifies projects that are a strategic priority of the hospital) and towards a bespoke donor centred approach. During the relationship building process, the development team aims to discover what philanthropic interests the prospect may have. Should a current campaign not fit with these, they then find a project which is more suited and aligns their philanthropic needs with those of the organisation. For example, the donor may have a very specific interest in phlebotomy and the fundraiser will work with the physician to produce a project which will make a significant difference to that specialism and a case for support that will motivate the donor to give. Total income has increased dramatically as a result. MHAF believes that a focus upon large campaigns for specific projects can isolate potential donors. They make the assumption that people want to give and then set about discovering what they would want to give towards.

RWJ view this process like pieces of a puzzle – taking the needs of the hospital and meshing them together with the interests and motivations of the donor to ensure they get a donation that may otherwise be directed elsewhere. Here, a prospect whose prime interest was religion and usually only considered Jewish charities was given the opportunity to see the potential impact of his donation in funding the hospital's Rabbi's salary for five years which would also bring significant benefits to education and healthcare.

MMHF employ a robust Funding Priorities Model that enables the effective screening and feasibility evaluation of project proposals. This recognises three strands of projects – hospital priorities, physician led concepts and a wish list of non-priorities that would support the work of the hospital. The latter two provide a readily available list to match specific projects to prospects interests. Furthermore, to be selected a project must have demonstrative support from physicians involved – they must be ready to open doors to prospects and guarantee active involvement from their staff.

Many of the major projects are similar to those selected in the UK – capital builds, medical equipment, staff training, research and innovative projects that bring advances in care quicker than they otherwise might. Fundraising provides margin money – it makes something extra happen. This ethos is well established within the culture of giving – excellence in their healthcare service is brought only through donations. One example of this in practice is the Rippel Breast Centre in MMHF. Fundraising income has enabled the hospital to provide their first class service in a magnificent spa-like setting - creating a calming, relaxing and almost luxurious facility. Similarly, SMC are providing a state of the art linear accelerator, patient resource library, wellness boutique, wig salon, healing garden and complementary therapy services as part of The Steeplechase Cancer Centre which boasts hotel-calibre private rooms with private baths, flat-screen televisions, DVD players and sofa beds for family members.

Projects selected therefore must provide the icing on the cake. This explicit aim allows them to select projects such as an Emergency Department build that may be viewed in the UK as the responsibility of the NHS and not therefore appropriate for fundraising. The contribution from fundraising allowed SMC to provide an Emergency Department that moved beyond expectations, becoming one of the largest and best equipped in New Jersey – recognising that people do not want to give to the norm but want to make something different happen.



This approach runs throughout all the hospitals visited – patients have private rooms with internet access, flat screen televisions, DVD libraries, sofa beds (see the impressive McKeen Suite at NYP above) – fundraising moves beyond improving patient care and towards a significant contribution to the patient experience. However some hospitals also raise money for operating funds which provides financial support for the running costs of the hospital (heating etc) so that that allows the hospital to afford to spend more on patient care. Perhaps something that may prove controversial in the UK?

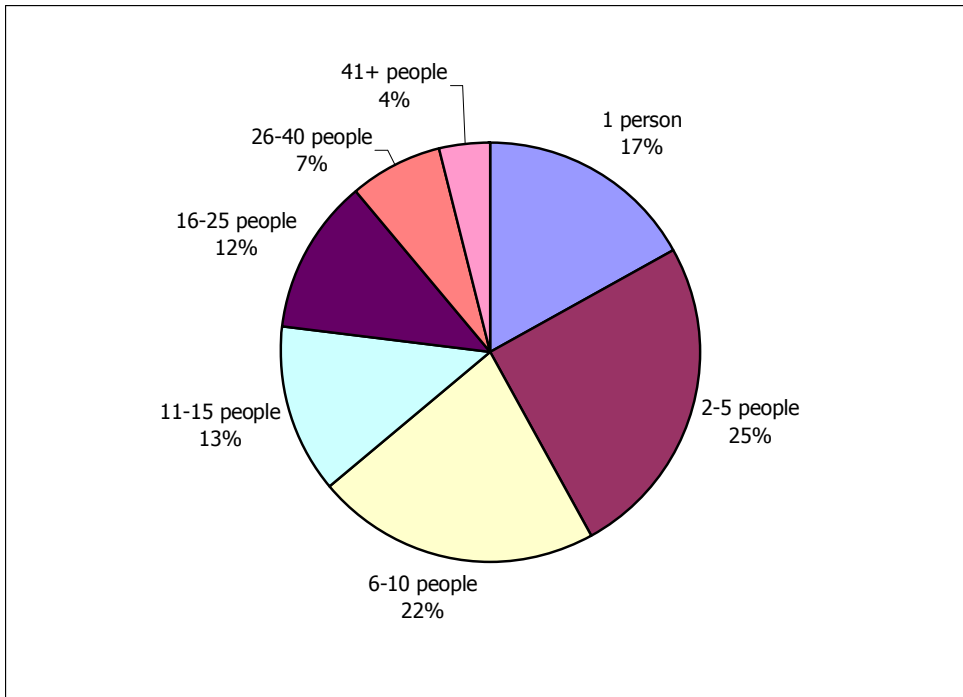
Without exception, fundraising supplements existing private funding for all major capital build projects – MMHF have recently completed a campaign for \$44m towards a total cost of \$130m for a new heart hospital and are now looking to raise \$4.5m towards a \$15m new Neonatal Intensive Care Unit. This clearly communicates that fundraising provides the extras – supplementing other finance to make a significant difference – echoing the most successful capital appeals in the UK where fundraising income top up financial backing from the NHS.

The US donor led approach to project selection enables these healthcare organisations to develop certain areas of healthcare that may not necessarily be appropriate for a major campaign thus allowing them to only select the most attractive projects for fundraising campaigns and avoiding any negative reaction to projects. Interestingly, NYP are very aware of the need to manage the balance of projects so as to avoid any criticism from the public and media. They carefully select projects so as not excessively prioritise their richer patients with exclusive facilities but bring benefits to the less wealthy and charity care patients. With many individuals and the media in the UK asking why we should need to fundraise to support the NHS, perhaps the US healthcare fundraisers face similar difficulties. The strong culture of giving goes a long way to address this but this is also managed through the careful selection of projects. To support the long term development of a change in attitudes towards NHS fundraising we simply must ensure that only those projects that clearly deliver benefits above and beyond that which the NHS can fund are selected for fundraising campaigns.

## 9. Staff

There is a clear and obvious correlation between the number of development staff and the level of income within the hospitals visited – with NYP employing 150 fundraising staff and raising \$200m per annum. Such is the scale of income generation within NYP that they employ three people just to track all donor recognition! The number of staff within the majority of US Foundations is similar to some of the most active NHS Trusts in the UK – with the majority employing between 2 and 10 people.

**Fig. 6: Number of development staff**



**Fig. 6: Number of staff and roles**

	No. staff	Fundraising roles held
New York Presbyterian & University Hospital of Columbia and Cornell	150	Director, principal gifts, major gifts, corporate/foundations, communications, special events, stewardship, research
Morristown Memorial Health Foundation	26	Chief Development Officer, communications, operations, gift processing, major gifts, special events, corporate, foundation, annual giving, special gifts, planned gifts, database, donor research, donor relations, administration
Somerset Medical Centre Foundation	9	President, Vice President, Assistant Vice President, community development, donor relations, special events, grant writing, administration
Robert Wood Johnson University Hospital Foundation	6	Director, major gifts/planned giving, events & annual giving, grants, administration
Meridian Health Affiliated Foundations	29	President, major gifts, administration

## 10. Reflections

The achievements of healthcare fundraising in the US are impressive but how much of this can be transferred to NHS fundraising in the UK? Whilst we must not lose sight of the fact that many NHS Trusts have incredibly successful fundraising departments and associated charities, if we could learn just one thing from the US it may help us rise to the ever increasing challenges that we experience in NHS fundraising. It would take a major change in attitudes and national culture to align ourselves with the level of giving seen in the US. However we, as NHS fundraisers, must stay passionate and proud about the contribution of fundraising to healthcare to help develop our own culture of giving. We may have a lot that we could learn from the US approach to major gifts fundraising and donor development but it seems clear that the key to the most successful healthcare fundraising is the active participation of the head of the hospital and the Trustees.

Karen Willis, Head of Fundraising  
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August 2007