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Dear Fellow CEO,

Even with the passage of the Health Care and Education Reconciliation Act (H.R. 4872) into law on March 30, 2010, philanthropy will continue to play a very significant role in health care delivery. While the bill aspires to provide health care coverage for an additional 32 million people, six percent of U.S. residents, more than eighteen million people, will remain uninsured. Additionally, among the 32 million people to whom the bill extends coverage, many may decide to pay the \$695 fine rather than try to cover the cost of health insurance. These people will most likely fall under the umbrella of charity care as well. In other words, the need for charity care is not going away. Nor is the need for health care philanthropy. In fact, philanthropy is likely to be even more important in the years to come in order for hospitals to meet the increase in demand for health care services.

Fundraising capital will be needed for medical equipment purchases, plant maintenance and capital improvements that hospitals can no longer fund due to shrinking operating margins. Philanthropic dollars will also be necessary to address growing physician and nursing shortages as well as for facility and program expansions in response to an aging population and growing community health issues.

Already, statistics show that the majority of funds raised for nonprofit hospitals are spent in areas other than charity care. The most recent *AHP Report on Giving, U.S.* indicates that only about six percent of the \$8.6 billion raised by U.S. health care organizations' philanthropic organizations and foundations in FY2008 was used to support charity care. The remaining 94 percent of funds raised went toward construction and renovation (25 percent), new equipment purchases (20 percent), general hospital operations (16 percent), other community benefit programs (12 percent) and hospital research and teaching (5 percent).

Even when coverage is extended to all citizens, philanthropy is still critical for health care delivery, as we see in Canada. The *FY2008 AHP Report on Giving, Canada* shows that approximately 47 percent of fundraising capital was spent on new equipment, 22 percent on construction and renovation, 10 percent on research and teaching, 8 percent on general operations and the remaining percent 13 percent spent on other community benefit programs, endowments and miscellaneous expenses.

In a recent discussion regarding this issue with one of our Canadian members, Allan Weatherall, CFRE, APR, director of development at St Thomas Elgin General Hospital Foundation, he explained that "even in Canada, where universal health care has been in place for many decades, money from the government alone cannot match the need. For example, in Ontario the community must contribute 10 percent of the 'bricks and mortar costs' for a major capital project and 100 percent of the expenditure for furnishings and equipment. For a new emergency department or operating room this can be very expensive. Recently, many local municipal governments have been approached to help fund the local share and have been receptive as they understand the need. In addition to major projects, numerous pieces of equipment need to be replaced annually because they are old and worn out. Therefore, in Canada, if we want first-class health care then we must also be willing to open our hearts and our wallets to help support our local hospitals over and above the taxes we pay to support universal access."

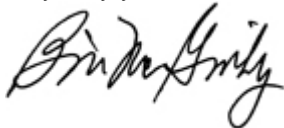
Other lessons can be learned from the state of Massachusetts, which instituted health care reform in 2006. Unlike Canada, the Massachusetts Health Plan does not cover everyone, but leaves Massachusetts nonprofit hospitals to cover the medical expenses of the uninsured—currently 4.1 percent of the population, or slightly more than 270,000 people. “That, coupled with the impact of the economy over the last two years (layoffs, downgraded plan benefits, reimbursement rate cuts, etc.) have actually lead to an increase in the ‘free and unreimbursed’ care provided by Massachusetts nonprofit health care providers,” says AHP Massachusetts member Betsy Wadland, CFRE, director of development at the Natick Visiting Nurse Association. “Our message is that there is more need than ever and fewer providers who are able to meet that need.”

Weatherall and Wadland’s insights show us that regardless of health care reform, philanthropy will continue to play an integral role in health care delivery. In fact, as I mentioned in my speech “[Living the Dream](#)” at the 44th Annual AHP International Conference, the combined transformation of the political and economic landscape has put more pressure on philanthropy, not less. It is up to us as leaders to define, articulate and direct this change to strengthen our institutions and the communities we serve.

I encourage you to meet with your counterparts in your philanthropic organizations and public relations departments to ensure continuity and consistency in drafting and delivering a message to your donors emphasizing the importance of philanthropy for the advancement of your institution’s mission.

As always, please feel free to call me at AHP’s headquarters at (703) 532-6243 with your advice and thoughts. My e-mail address is bill@ahp.org. I look forward to hearing from you and to continuing our conversation.

Very truly yours,

A handwritten signature in black ink, appearing to read "Bill McGinly". The signature is fluid and cursive, written in a professional style.

William C. McGinly, Ph.D., CAE
President and Chief Executive Officer
Association for Healthcare Philanthropy