Historical Overview of Philanthropy and Aging

By Audrey S. Weiner and Jeffrey R. Solomon

Philanthropy is America's most distinctive virtue. There is no other aspect of American life that is so vast in scale, so rooted in tradition, so broadly supported by law and public policy. (Payton, 1983)

As noted by Toqueville in the 1830s, Americans have long had a unique capacity to organize themselves for the public good. Whether driven in the nineteenth century by distrust of government or the communitarian spirit of the pioneer, this attribute developed through the years that followed. Organized philanthropy, the golden legacy of the robber-baron generation, continues to expand; today there are almost 60,000 American foundations, with a steady growth in both numbers and value of assets. Older people and the field of aging are among the beneficiaries. Philanthropy—love of humankind expressed through manifest acts of goodness—and charity—benevolent goodwill, especially toward the needy or suffering—were firmly ingrained concepts and realities in biblical writings and the middle ages. The early Christian church and wealthy individuals founded hospitals, distributed food, and established forms of relief for the needy. The Elizabethan Poor Laws of 1603 brought the government into caring for the poor, which had previously been a strictly private charitable endeavor. Individuals have continuted to engage in philanthropy—expressing the love of humankind through manifest acts of goodness, or, as Merriam-Webster (2003) defines philanthropy, "active effort to promote human welfare." Charity Merriam-Webster defines as " . . . generosity and helpfulness, especially toward the needy or suffering; aid given to those in need."

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In a study of strategic giving, Frumkin (2006) defines charity as "uncomplicated and unconditional transfer of dollars or assistance to those in need with the intent of help."

It was the twelfth century philosopher Moses Maimonides who described charity as having eight distinct levels. They range from the first step of charity—giving reluctantly—to the ultimate form of giving—working with others in partnerships or making loans in order to allow the recipients to live independently and provide for themselves in the future (Frumkin, 2006). The intervening steps include giving cheerfully but not sufficiently; sufficiently but only after being asked; without being asked but putting the gift in the recipient's hand in a way that makes the individual feel ashamed; to an anonymous recipient but receiving recognition in the community; to a known recipient and remaining anonymous; and, in a way where neither the donor nor the recipient is aware of the other's identity.

In fact, the historic and practical idea to remove a stone from the wall of a synagogue and put the almsbox there so that the donor could put the gift in one side and the recipient would remove it from the other (both remain anonymous), is suggested as an altruistic and real response to giving at the higher levels (Payton, 1995).

Building on this age-old construct, Frumkin offers a series of concerns about the unintended consequences of charitable giving as it is performed by the philanthropic today. These concerns are that (1) the poor will be humiliated; (2) that the gift does not focus on the root of the actual problems, but only on the symptoms;(3) that the gift serves to continue a lack of professionalism in addressing the core issues of health and social service conceffis; and (4) that the gift allows government to remain uninvolved in its fundamental responsibility to address such deep-rooted problems.

In contrast to individual charity, "philanthropy" describes all types of private giving for public and private purposes. Philanthropy is more likely to include larger gifts that are more carefully rationalized, less personal and spontaneous, and more directed to the future (Payton, 1983). Because recipients of philanthropy are usually anonymous, such giving addresses Frumkin's concern regarding the potential debasing and humiliation of the poor through charity.

The evolution from individual and personal charity and philanthropic giving to the modern American foundation dates back to the end of the American Civil War. During the last decade of the nineteenth century, several individuals impassioned by the outcomes of the Civil War were moved to link that passion to disciplined and focused giving. The endowments they created began to transform the process and system for holding and distributing charitable resources. The concerns of these individuals were not only with the outcome of the work but with the rationalization, reorganization, and professionalization of charitable work (Smith, 1999).

The most well known of these nineteenth-century endowments was the Peabody Education Fund for regional reconciliation after the Civil War and education in the south. The Slater Fund Endowment, created in 1882, focused on the development of models of education for blacks in the south (Smith, 1999).

These individual philanthropists and the endowments they created set the stage for the next generation of philanthropists, namely Rockefeller, Carnegie, and Slocum. Carnegie's view that surplus should be distributed during one's lifetime to benefit society provided the motivation for the creation of the Carnegie Foundation and its many affiliated philanthropies. While private foundations were rare at that time, creation of a foundation became an appealing mechanism for wealthy individuals to use the surplus wealth that they had amassed during their lifetime and ensure a legacy of their own direction (Frumkin, 2006). Thus, the foundation framework was built on the experiences of individual endowments, individual philanthropy, charity, and the giving of alms, and could be focused on a narrow or limited range as defined by the donor.

Again, in contrast to the earlier endowments of Peabody and Slater, these new foundations with their defined purposes developed governance structures relying on self-perpetuating boards of directors and missions to serve the public good. They clearly represented the development of a more systematic and rational approach to philanthropy (Smith, 1999).

The link between charity directed to older people and those who care for them and numerous religions also has a long and relevant history. Christian philanthropy is rooted in the ministry of Jesus, in which he paid special attention to the poor, the sick, and the socially marginalized. Modern Christian philanthropy in aging focuses on tending to spiritual and emotional needs, companionship, social engagement, and remaining active. Hospice care is also a priority.

Jewish heritage calls upon every person to partner with God in the healing of the world. Beginning with the basic tenet of the Fifth Commandment, "Honor thy father and thy mother: that thy days may be long upon the land which the Lord thy God giveth thee," care for older people was always seen as a responsibility of a righteous individual. Today, Jewish foundations emphasize healthcare, research in aging, and the importance of keeping older adults connected to their religious community and customs.

An interesting aspect to care of the aged is provided in Islam, wherein the tradition is as follows:

> Serving one's parents is a duty second only to worshipping and it is the parents' right to expect it. It is considered despicable to express an irritation when, due no fault of their own, the old become difficult to handle. (Clemetson, 2006)

For Muslims it is considered almost shameful to enlist outside assistance in pursuing one's obligation to one's parents. In fact, the development of nursing homes and assisted living services for the Muslim community is quite controversial (see, for example, Clemetson, 2006). As a result, while a sophisticated Islamic tradition of charity to others exists, because each family is expected to care for its own elders, Islamic charity does not tend to focus on the elderly as do the charitable practices of the other Abrahamic religions.

Given the long-standing strong linkage between religion and service, the analysis of private foundations' role in providing financial support to religiously affiliated organizations that provide social services is relevant.

The Roundtable on Religion and Social Welfare Policy's analysis of this link is instructive (Scott, 2003). In 2000, for example, approximately 12 percent of the 2,740 private independent foundations and 230 community foundations with total annual giving of $1 million dollars or more expressed an interest in funding (nongovernmental) social services and religiously affiliated organizations. In the Roundtable analysis, social services were categorized into twenty subject areas. The amount of giving to support the faith-based social services was approximately $68.8 million. Giving to senior services ranked sixth in the list of twenty, with $3,851,889 million dollars, or 5.6 percent of the total. Aging ranked behind the grant areas of human services ($16,167,320); community healthcare ($8,718,820); youth development ($6,673,921); community development ($6,668,5380); and homeless services ($5,658,789). The average grant for senior services was slightly above $59,000, ranking number fourteen of twenty in this analysis (Scott, 2003).

The analysis further reported that large, independent community foundations demonstrate a significant interest in support for faith-based social services. The authors also note that private foundations make substantial contributions in the form of in-kind gifts (including material goods and volunteer support), the dollar value of which is unknown (Scott, 2003).

The specific linkage between faith-based philanthropic foundation support and aging services was strongly demonstrated as early as the nineteenth century in the creation of facilities to provide what was then state-of-the-art housing and nursing home care. For example, in Philadelphia, the first so-called old-age home, The Indigent Widows and Single Women Society, opened in 1817 to women who were white, Christian, and (formerly) middle class (Haber, 1983). Following the Civil War, middle- and lower-class Americans followed the example of wealthy individuals and built homes for elders in their own communities. For example, during a period of prosperity in Buffalo, New York, Methodists, Baptists, and Lutherans established facilities that modeled the homes built earlier by the Episcopalian and Presbyterian communities (Achenbaum, 1978).

In New York in 1870, Hannah Leo established a home for aged people of her religion (Jewish) who were without means of supporting themselves. A description of the development of the home, written soon after, follows:

> . . . but for private charity [these aged without means] would be compelled to spend their days in the public almhouse. . . . Mrs. Leo contributed mostly to its maintenance at first but the wealthy Hebrews of New York were not backward in helping to enlarge its sphere of usefulness, and little difficulty was experienced in obtaining sufficient money to provide for the accommodation of all of the really deserving cases brought to the attention of the Trustees. (Hubert, 1890)

That home became what is now the Jewish Home and Hospital Lifecare System. By 1900, religious entities supported 40 percent of all programs in the United States from which older adults benefited (Achenbaum, 1992).

In this early part of the twentieth century, philanthropists' interest in aging broadened beyond the creation of facilities for shelter and healthcare and began to address the need for investment in the research that would be required for the reformation of service provision. For example, portions of the gift of $3 million bequeathed by Cleveland's Benjamin Rose in 1911 for "respectable and deserving older adults who lived at home and required help" were expressly to enable researchers to study ways to maximize benefits to older people in the community (Achenbaum, 1978). In fact, by the 1930s, private philanthropy had become the major source of funds for aging research, as Achenbaum (1991) notes in his brief history of foundation funding in aging.

Building networks to nurture creative thinking about old age also became a priority of foundation support at that same time. The seminal example of that is the 1937 conference sponsored by the Josiah Macy Jr. Foundation in which gerontology was viewed as a field of scientific inquiry for the first time. The Ford Foundation's creation of the National Council on Aging in 1950 is another historic landmark.

More recent decades have seen the development of independent foundations, family foundations, corporate foundations, and community foundations. These are further divided into operating foundations and grant-making foundations. Additionally, many healthcare facilities have created their own related foundations to engage in resource development and grant making, unencumbered by complex government reimbursement systems, which can serve as a disincentive to voluntary contributions.

Independent foundations, including family foundations, constitute about 89 percent of all foundations and account for some three-quarters of charitable giving. Since the late 1990s, the number of family foundations has increased nationally by more than 60 percent. Corporate foundations constitute almost 4 percent of all foundations and give slightly more than 11 percent of total gifts (Wolf, 2006) (see also Regenstreif, this issue).

In 1991, the Burden Foundation supported a study of foundation grant-making trends in aging. The time frame examined was 1983 to 1987, and data for the study were retrieved from the Foundation Center grants database and augmented by grant-maker surveys and interviews (Greenberg et al., 1991).

During that five-year period, annual funding in aging increased from $39 million to $68 million, an increase of 75 percent in current dollars or 51 percent in inflation-adjusted dollars. (This amount exceeded the 44 percent increase in overall foundation giving at that time.) The number of grants in aging rose by 44 percent (from 762 in 1983 to 1,096 in 1987). Further, data showed that 415 foundations awarded more than 4,800 grants in aging during those five years, totaling slightly more than $290 million dollars. Aging's share of overall foundation funding ranged from 2.0 to 3.0 percent.

In this Burden study (1983 to 1987), the majority of these funds were given specifically for health programs. At 53 percent, program development garnered over half of the foundation funding in aging, far exceeding the 37 percent for program support or the 17 percent for research.

Ninety percent of all funding for aging during that five-year time frame was distributed to three organizational types:

- Direct service agencies (43 percent)
- Educational institutions (24 percent)
- Hospitals and medical facilities (20 percent)

Twelve percent of the grant dollars were given to institutional long-term-care programs (nursing homes), which are differentiated in this study from health or medical programs. Support for services for elders in the community received 20 percent of giving in aging. Intergenerational programs linking youngsters and older adults represented 7 percent of the funding. The study concluded that aging's 2 percent to 3 percent share of funding was unlikely to grow.

Wolf's (2006) review of a national sample of more than 1,000 foundations that list aging as a giving area notes that from 1998 to 2003, grants to aging as a percentage of the total of grants to all population groups ranged from 2.1 percent to 2.5 percent. As a percentage of total dollars, according to the Foundation Center's database (a national sample of the 1,010 larger United States foundations reviewed for grants

of $10,000 or more), the range was 1.6 percent to 2.1 percent.

In 2003, this number totaled $231,567,700, and in 2004, $243,115,000, a 4.9 percent increase over the prior year. This same sample was searched by program area. While clearly not mutually exclusive, grants were given in program areas as follows: aging, 3,806; nursing homes, 351; senior continuing care, 250; geriatrics, 124; gerontology, 72; and geriatric research, 41.

The type of support given through these awards includes program development (1,430 grants); general operation support (697 grants); research (130 grants); capital campaigns (41 grants); and seed money (30 grants).

In 1982, Grantmakers in Aging was created to enable program officers and others interested in aging to come together, learn from each other, exchange ideas, and indeed develop new ideas (Farquhar, in Sinclair, 2006).

An emerging trend emanating from the impact of entrepreneurial-technology philanthropists is the emphasis on leverage. Increasingly, foundations associated with this approach are more "businesslike," wanting clear benchmarks and evaluative data so that "return on philanthropic investment" can be measured.

The Burden study of 1991 was useful in articulating priorities for foundations, concluding that the most urgent areas for grant making in aging were the following: (1) financing long-term care; (2) ensuring access to quality healthcare; and (3) allocating resources to meet the needs of all generations.

Fifteen years later, Farquhar (in Sinclair, 2006) stated that foundation priorities included productive aging, healthy aging, aging in place, end-of-life and palliative care, and transportation. Wolf (2006) adds to that list caregiving and geriatric mental health.

Farquhar (in Sinclair, 2006) notes that there are "not enough foundations focused exclusively on aging. . . . yet on the positive side funding for aging isn't necessarily being done in isolation. Increasingly it is viewed as a cross-cutting issue. . . ."

By drawing their attention to the matter, this special edition of *Generations* has the potential to engage funders in addressing why aging is not an area for more exclusive focus and how this situation can be changed ∞

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