Inequality in the Spatial Allocation of Social Services: Government Contracts to Nonprofit Organizations in New York City

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ABSTRACT Publicly funded social services are an increasingly important component of social provision spending, accounting for approximately one-fifth of today’s welfare state expenditures. These funds are often allocated through purchase of service contracts between state and municipal agencies and third-party providers, usually nonprofit organizations. This study uses a unique dataset of government contracts with nonprofit organizations in New York City between 1997 and 2001 to study the relationship between the allocation of social services funding across neighborhoods and neighborhood need. We distinguish between local organizations serving their immediate neighborhoods and distributive organizations serving multiple neighborhoods. Overall, contract dollars allocated to both organizational types are positively associated with socioeconomic disadvantage, although distributive organizations are less likely to be physically located in needy neighborhoods. However, contract dollars for services targeted to specific populations are sometimes negatively associated with the prevalence of these targeted populations, especially when those contracts go to distributive organizations.

INTRODUCTION
The US welfare state has a long tradition of joint public-private provision. Aspects of the nation’s history, including federalism, the power of interest groups, and a long-standing preference for a small state bureaucracy have produced, sustained, and expanded this arrangement for nearly 2 centuries (Salamon 1987; Clemens 2006; Morgan and Campbell 2011). The earliest
forms of state and local assistance to the destitute included agreements with private households to shelter and feed public charges in exchange for their labor, as well as the distribution to needy families of basic household goods (food, fuel, etc.) purchased from local merchants (Patterson 1994). By the mid-nineteenth century, state governments were routinely subsidizing private agencies to take care of orphans, the disabled, the mentally ill, and the sick, often because these subsidies amounted to a fraction of the cost of setting up and operating public institutions to provide the same services (Barrows 1885; Department of Finance Charitable Institutions Division 1904; Salamon 1987). With the exception of federal Civil War pensions, these various noncash forms of assistance to the poor constituted the bulk of the US welfare state until the early twentieth century, when “mothers’ pensions” (Leff 1973, 397) finally broke through the states’ strong distaste for “outdoor” relief (i.e., income support; Patterson 1994, 20).

The Social Security Act of 1935 (42 U.S.C.) marked a sea change in US welfare provision. Not only did the federal government take on dramatically enhanced responsibility for citizen well-being, but income support took center stage. At the same time, however, the act provided for a range of service-based forms of assistance, including maternal and child health services, child protection, vocational rehabilitation for the disabled, and public health services. In keeping with longstanding traditions of public-private provision of noncash assistance, it explicitly allowed for states to purchase these services from private charitable organizations (e.g., 42 U.S.C. Title V, Section 503(a)(6); Title V, Section 513(a)(6)). Amendments to the act in 1962 and 1967 set the stage for significant growth in service-based forms of aid to the poor, often through purchase-of-service contracts with private nonprofit organizations (Cohen and Ball 1968; Derthick 1975; Lynn 2002). The creation of Medicare and Medicaid in 1965 opened up a new conduit for the public purchase of medical and related services.

In sum, while income transfers may be the most visible form of present-day public welfare provision, the US government arguably spends at least an equal amount on services to help secure citizens’ well-being. For example, 2010 data show that income transfers represented approximately 45 percent of federal social welfare spending, while medical insurance accounted for about 38 percent, and social services approximately 17 percent (Center on Budget and Policy Priorities 2012; United States Department of Health
Public spending on services is a critical part of the social benefit package of low-income people. As Scott Allard (2009) documents, US governments spend far more on social services for the poor than on means-tested income transfers. Furthermore, the 1996 welfare reform, which limited the time poor people can receive income transfers, is likely to make social services an increasingly large component of this group’s social benefit package (Allard 2009).

For some time now, a large majority of publicly funded social services have been provided by private, mostly nonprofit organizations under contract with the government (Hodgkinson and Weitzman 1986; Katz 1986; Smith and Lipsky 1993; Salamon 1995). The importance of these services to the well-being of low-income people has led to 3 decades of scholarship that explores the various ways that government funding impacts nonprofit organizations, including their programming, staffing, management, governance, client selection, outcomes, and related concerns (Kramer 1982, 1994; DeHoog 1984; Grønbjerg 1993; Smith and Lipsky 1993; Provan and Milward 1994; Lynn 2002; O’Regan and Oster 2002; Luksetich 2008; Garrow 2011; Mosley 2012). One such line of research explores access to service providers as a function of providers’ geographic location (Bielefeld 2000; Twombly 2001; Allard, Tolman, and Rosen 2003; Joassart-Marcelli and Wolch 2003; Twombly and Auer 2004; Allard 2009). This work helps raise the question of how distinctive features of the social services form of welfare provision might impact individuals, families, and communities.

We argue in this article that social services are marked by two provision mechanisms distinct from those that characterize income transfers or government-sponsored medical insurance and thus that it is necessary to examine more fully how social services become available to citizens. This study goes beyond prior work that investigates whether service-providing

1. This estimate of income transfers includes Social Security (retirement, disability, and survivors payments), Temporary Assistance to Needy Families (TANF), Supplemental Security Income (SSI), the Earned Income Tax Credit (EITC), and the Child Care Tax Credit. The estimate of medical insurance includes Medicare, Medicaid, and the Child Health Insurance Program. Calculations of these percentages, based on these two sources, are available upon request.

2. The time limits are true of TANF benefits, though not of SSI benefits, which some recent research shows may be becoming a partial substitute for TANF (Zedlewski and Alderson 2001; United States General Accounting Office 2002; Wamhoff and Wiseman 2005–6).
organizations are located in areas where needy citizens live (Bielefeld 2000; Twombly 2001; Joassart-Marcelli and Wolch 2003; Twombly and Auer 2004; Allard 2009) to inquire about the extent to which these organizational turnkeys actually channel public dollars to those areas. We draw on a unique data set to explore how public funding for social services is distributed across geographic space and to investigate whether there is a spatial match between socioeconomic need and the distribution of these public dollars.

**ALLOCATION AND ACCESSIBILITY OF PUBLICLY FUNDED SOCIAL SERVICES**

We estimate that social services represent approximately 17 percent of the federal social welfare budget, though this figure surely underestimates the total amount of public resources spent on social services, for two reasons. First, a number of studies note that estimates of federal social services spending are far less reliable than estimates of income transfer and medical insurance spending, due to the difficulty of locating service-based expenditures within complex public budgets (Smith and Lipsky 1993; Garfinkel et al. 2005; Allard 2009). Second, state and local governments usually allocate additional funds for social services, indicating that the amount of public funds spent on these services goes significantly beyond the federal amount.

The accessibility of social services also differs from that of other public provision; the mechanisms by which social services become available to individuals differ from how people access either income transfers or government-sponsored medical insurance. Income transfer policies are based on standardized eligibility rules and come directly to individuals in the form of automatic payments. Most importantly, with the exception of TANF, there is no spending cap for funding the various income transfer programs, Social Security, SSI, EITC, and the Child Care Tax Credit. As such, funding and delivery of income transfers are tightly linked. Government-sponsored medical insurance also has standardized eligibility rules and, furthermore, is an entitlement. Although insured individuals

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3. For a study of the geographic distribution of private philanthropic dollars to social service providers, see Reckhow and Weir (2012).

4. Some of the funds allocated by states come from the federal government, such as Community Development Block Grant or Social Services Block Grant funds. In most states, however, state and local tax-levy dollars are added to the federal funds.
must find their own service providers, payment for service usually goes directly from government to the provider, ensuring a strong link between funding and delivery of medical insurance. Of course, eligibility for both income transfers and medical insurance is determined by caseworkers who may apply the same rules differently for different recipients (Lipsky 1980; Watkins-Hayes 2009; Soss, Fording, and Schram 2011). Compared with both income transfers and medical insurance, however, the social services piece of the welfare state is characterized by mechanisms that separate funding from service delivery.

First, executive agencies at the local, state, and federal levels generally fund their social services budgets through discretionary legislative appropriations. These appropriations are usually capped at a fixed level that may or may not be related to citizen need. While state and local governments receive some social services funds through formula-based allocations from higher levels of government (e.g., the federal Social Services Block Grant sends funds to state governments based on population), the overall appropriation is still fixed by legislative mandate. This is distinct from either income transfers or medical insurance, where any individual who meets the eligibility criteria can receive assistance. In contrast, the funding mechanism for social services means that citizen access to these services frequently constitutes a zero-sum game.

A second major distinction in the social services delivery mechanism is that a large proportion of these services are contracted out, usually to private, nonprofit providers. This creates an indirect relationship between government and its beneficiaries, mediated by the private, service-providing organization (cf. Milward and Provan 2000). The accessibility of publicly supported social services thus depends not only on individual eligibility but also on the location of service providers and the ease of finding providers. Whereas income transfers are sent directly to individuals via direct deposit, a check, or an electronic benefits card, both social services and medical services must be accessed at a particular location (e.g., Fossett and Peterson 1989; Mitchell 1991; Allard et al. 2003; Rodriguez et al. 2007; Allard 2009; Ku, Jones, and Shin 2011). For example, health, mental health, and drug treatment counseling may be delivered at community clinic sites. If these clinics are located close to clients’ homes, they are more likely to attend regularly than if the clinics are far away (Kaplan et al. 1998; Appel et al. 2004; Choi and Gonzalez 2005; Yang et al. 2006; Bazzoli et al. 2012). Similarly, subsidized housing is built in specific neighborhoods. If this housing is located far away from friends...
and family, residents are more likely to suffer from a lack of social support (Goetz 2003; Venkatesh and Celimli 2004; Briggs, Popkin, and Goering 2010). In other words, the location of medical and social services intersects with other aspects of individuals’ lives, affecting the extent to which clients (and potential clients) benefit from services. Thus, the bureaucratic process by which these services are allocated to particular places is critical to analysis of the welfare state.5

In addition to the distinctive mechanisms by which publicly funded social services become available to citizens, the ongoing devolution of policy decisions from the federal level to states, counties, and municipalities calls our attention to the actions of these lower levels of the federal system. Devolution has made state and municipal officials increasingly responsible for deciding how to spend federal dollars in a variety of program areas (Caputo 1994; Conlan 1998; Winston 2002; Gainsborough 2003; Fellowes and Rowe 2004; Lambright and Allard 2004; Bishop 2006). Social services funding combines federal dollars with state and local appropriations, and decisions about how to allocate this money—including which nonprofit organizations will receive government contracts to deliver social services—lie in the hands of state and local executive agency staff. Analyses of the current relationship between government and nonprofit organizations thus need to focus more on state- and city-level data (e.g., Grønbjerg 1993; Savas 2002).

After state and municipal legislatures determine budget allocations for particular areas of social service, such as day care, elderly services, or employment training, decisions about how to allocate those dollars pass to the executive agencies. Sometimes, these agencies use funds to provide services directly to clients. Allard, for example, finds that in three large US cities, between 25 and 35 percent of social service providers are government agencies (Allard 2009, table A5). In most cases, however, government agencies construct bidding processes and invite private organizations, most of which are nonprofit organizations (NPOs), to compete for the opportunity to provide services. Which NPOs receive contracts to deliver services has direct

5. The service delivery mechanism for Medicaid, the main publicly supported medical insurance program for the poor, is complex. In many cases, medical providers submit claims directly to Medicaid on behalf of Medicaid-enrolled individuals, and Medicaid pays the provider; this has similarities to the mechanism for income transfers and Medicare, although providers must still be located and accessed. In other cases, Medicaid allocates a lump sum to a provider for a specified quantity of a particular medical service; this mechanism is largely parallel to the social services allocation mechanism described here.
consequences for the geographic locations where services may or may not become available, thus determining who is most likely to access those services. In other words, contracts sent to NPOs in particular places mean that residents of those places are more likely to access those services, while equally needy people in places without such contract resources will be less able to obtain services. This structure of distribution demands the question of what actually happens in the process of government contract allocation to NPOs.

A few existing studies examine the location of NPOs within cities or metropolitan areas in order to understand the relationship between citizens’ socioeconomic need and the availability of NPO services (Wolpert 1993; Bielefeld 2000; Twombly 2001; Joassart-Marcelli and Wolch 2003; Twombly and Auer 2004). Allard (2009) improves substantially on this approach by estimating the relationship between NPO location and the concentration of low-income people within a three-mile radius. Both techniques, however, are hampered by the reality that the existence of an NPO in a particular location is an indirect proxy for understanding the availability of service resources in that location. For example, one neighborhood may have multiple NPOs whose collective small amounts of government contract dollars add up to substantially fewer resources than another neighborhood with one or two NPOs with large contract allocations.

Since many nonprofit social service providers receive the large majority of their funds from government sources (Rosenthal 2000), the actual number of government dollars allocated within a given neighborhood is a better measure of service availability than the existence or number of NPOs in that neighborhood. In what follows, we draw on a data set constructed by the authors to examine the distribution of government contract dollars to NPOs in New York City. Our primary question of interest in this article is the relationship between the allocation of these funds and neighborhood need. We define need both broadly in terms of socioeconomic disadvantage and narrowly in relation to specific target populations for certain services.

**METHOD**

**DATA**

The primary data for the project are administrative records of all contracts to nonprofit organizations located in the five boroughs of New York City (Manhattan, Brooklyn, the Bronx, Queens, and Staten Island), from all
New York City and New York State government agencies. These records were obtained from the New York City comptroller and the New York State comptroller, respectively, via requests filed under the city’s and the state’s separate freedom of information laws. The city and state comptroller’s offices are centralized record keepers for their respective governments’ expenditures. The data contain the full population of contracts to nonprofit organizations from 1997 through 2001. Data were transmitted to the authors in electronic database format.

Each contract entry includes information on the name of the nonprofit organization receiving the contract; the street address, city, and zip code of the organization; the amount of the contract (in dollars); the start and end dates of the contract; and a brief narrative description of the contract purpose. The contracts from New York City also contain information on the community districts (administrative geographic units described below) where the service funded by the contract was to be provided. An organization may receive one or more contracts during the time period covered by the data.

The original data contained contracts that were active between the years 1997 and 2001 (inclusive), either because their start date fell within this time frame or because their start date was earlier but their end date fell within this period or later. Many of these contracts were for single years, but there were also numerous multiyear contracts (45.5 percent). We assume that funding will be uniformly distributed over the length of the contract and so we determine the amount of funding for each contract within our time interval by multiplying the total amount of the contract by the proportion of the total contract time that fell within the interval.

The data set contains 25,984 unique contracts; 5,241 of them come from New York City government agencies, while 20,653 come from New York State government agencies. Over our 5-year period, 5.2 billion dollars were allocated to organizations by New York City and 4.2 billion dollars were allocated to organizations by New York State.

CLASSIFYING CONTRACTS BY SERVICE TYPE

We assigned each contract to one of 23 service-type categories: advocacy, community development, crime, culture, day care, disabilities, education/training, elderly, employment training for the disabled, preemployment skills training, other employment-related, foster care, family preventive services, general operating support, AIDS-related health, mental health,
substance abuse treatment and prevention, other health-related, housing, immigration, rent/physical plant, youth programs, or other.6 Service codes were assigned based on the entry in the contract purpose field of the original data. In nearly all cases, this description was for a single type of service. Assigning service codes to contracts rather than to organizations addresses the issue that many nonprofit organizations provide multiple services, rendering organization-level service codes, such as the National Taxonomy of Exempt Entities Core Codes (NTEE-CC; National Center for Charitable Statistics 2013) poor proxies for the availability of specific services in neighborhoods.7 Contract-level service codes allow us to track the actual dollars spent on particular services in particular places.

We developed our coding scheme based on categories that emerged from the entries in the contract purpose field of the data set. We developed the initial set of coding categories using an open-coding approach (Miles and Huberman 1994) applied to a random selection of approximately 20 percent (n = 5,000) of the contract purpose entries. We then applied those initial categories to an additional randomly selected 20 percent (n = 5,000) of the contract purpose entries to examine how well the categories fit to additional data. After some adjustments, including the addition of new categories and the collapsing of some of the initial categories, we applied the revised categories to a new random selection of 20 percent (n = 5,000) of all the contract purpose entries, including entries that had been previously coded, to assess internal validity. We then developed a codebook for use in coding the rest of the data. Each code includes both a general description of the category, as well as a set of specific, repeated contract purpose entries found in the data that are assigned to each code.

We chose an emergent coding procedure rather than applying the NTEE-CC codes to the data, to accommodate both the contract-level...
(rather than organizational-level) approach, and the peculiarities of the New York City case. Four of our 23 codes fall into two different Major Group NTEE-CC codes (i.e., the letter codes, such as A for “arts, culture, and humanities”). Six of our codes fall within the single NTEE-CC P category for “human services.” Three of our codes fall within the single NTEE-CC J category for “employment.” Eight of the NTEE-CC letter categories are not applicable to our data. Three of our codes do not fall into any NTEE-CC letter category (general operating support, rent/physical plant, and member item).

In addition to our 23 service codes, we also categorized some contracts as member items. Member items are allocations of government funds that are awarded by elected members of the legislative branch, rather than by the bureaucratic agencies controlled by the executive branch. In New York, member items have long been part of the city and state budget processes. The practices governing member-item spending at the city and state levels are generally the same. In each case, the leader of the legislative body (in the city’s unicameral legislature, the city council speaker; in the state’s bicameral legislature, both the assembly speaker and the senate majority leader, acting independently) allocates a pot of funds to each legislator in his or her body. These amounts vary substantially among legislators, and in general favor members of the party that controls the chamber. The legislative leader usually reserves the largest pot of funds for his/her own use (Hakim 2007; New York Times 2011). Each legislator can use the money to allocate contracts of any size to nonprofit organizations of his or her choosing.

Unfortunately, member items were not identified in the city and state data in the same manner, creating some difficulty in making the two data sets symmetric. In the state data, member items were identified as such in the contract purpose field. In most cases, being a member item was the only description of the contract purpose; that is, there is no indication of the substantive service area to which these contracts were directed. In contrast, although we have verified that the city data does contain the member item contracts, only three member items were identified as such.8 Instead, the city data’s contract purpose field contained a description of the substantive service for which the contract was used. Thus, for the state data we have more information on which contracts were member items, but these member items often cannot be traced back to the actual ser-

8. Interview with staff member at the New York City Council budget office, February 5, 2013.
vice being provided. Overall, although the number of member item contracts in the state data is large, these contracts only account for 3 percent of total state funding. We experimented with sensitivity analyses by removing identifiable member items from both the state and city data, and our results are largely robust to this deletion. For the analysis that follows, we include member item contracts.

ALLOCATING CONTRACTS SPATIALLY

We identify the spatial location of each contract based on the street address of the receiving organization. However, because contract administration is carried out at the program level (this level is a sublevel of the executive agencies, which run multiple programs), the comptroller’s offices frequently had different versions of the same organization’s name and address. In order to ensure the accurate aggregation of all relevant contracts to a single organization, we standardized all versions of the name and address found in the original contract records.\(^9\) Using this process, we determined that the 25,984 contracts contained in the original data were awarded to 3,725 unique nonprofit organizations.

Street addresses were then geocoded to two different boundaries of analytical interest: New York City health areas and New York City community districts. New York City health areas were drawn in 1927 in order to provide an administrative boundary for tracking health data that was larger than a census tract, but small enough to constitute a socially meaningful community (Drolet and Guilfoy 1930). Originally, there were 270 health areas, later expanded to 354. These analyses use health areas as the primary proxy for neighborhoods. A number of health areas are currently manufacturing and industrial areas or public parks and other green space. After excluding these cases, there are 336 health areas for analysis.

New York City community districts are administrative boundaries established in 1975 to provide city government with a local policy advisory mechanism. There are 59 community districts, each with a board composed of up to 50 unsalaried, appointed members; the boards have advisory powers only. These geographic areas are generally too large to think of meaningfully as neighborhoods, but the city data provide information

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\(^9\) Regrettably, neither the state nor the city would release the federal Employer Identification Numbers of the contract recipients, citing privacy concerns not overridden by the freedom of information laws.
on the community district(s) where the service paid for by the contract would be delivered. These indicated service locations are sometimes different from the community district where the organization is located. We utilize this information to overcome an important limitation discussed below.

IDENTIFYING DISTRIBUTIVE ORGANIZATIONS

In determining the geographic allocation of contract dollars, it is important to distinguish between organizations that spend money in their immediate geographic area and those that distribute their services more widely. For instance, the Throggs Neck Homeowners Association’s address is listed in the database as 256 Throggs Neck Boulevard in the Bronx, and because the organization serves residents of the Throggs Neck neighborhood only, we term it a local organization. By contrast, the Trust for Public Land, an environmental organization whose address appears in the database as 666 Broadway (in lower Manhattan), used contract dollars to support activities at multiple locations in New York City. Thus, we term it a distributive organization. Using this logic, for each organization that appears in the data set, we have added a field that indicates whether an organization provides services in its immediate area (a local organization) or provides services more widely throughout the city (a distributive organization).

Each organization was assigned to be either local or distributive based on information gleaned from either prior ethnographic research conducted by the first author (Marwell 2004, 2007) or an online search for the organization. Online searches produce a variety of information, including organizational websites, press articles, user evaluations, IRS Form 990s, New York corporation status, and so on. Using these multiple sources, we determined an organization was a local organization if it had a mission statement or client service area that focused on up to three adjacent neighborhoods. Using these same sources, we determined an organization was distributive if it had a mission statement or client service area that covered more than three adjacent neighborhoods, one or more boroughs, or the entire city.¹⁰

¹⁰. Online searches were conducted in 2011, which is at least 10 years after the contracts in the data set were allocated. We recognize that the local or distributive status of organizations may have changed during this period, especially in the case of local organizations that
Once the coding rules for local and distributive organizations were determined, the authors conducted a reliability test. Each author coded the same random sample of 400 organizations (approximately 10 percent of the total organizations), and the two authors’ codes were then compared. Intercoder reliability was determined to be 92 percent. With intercoder reliability sufficiently established, codes for local and distributive organizations were applied to all remaining organizations in the data set.

Distributive organizations account for the majority of money allocated (state: 71 percent; city: 69 percent), despite making up only around half of the contracts awarded (state: 52 percent; city: 45 percent). This is because the mean dollar amount of contracts awarded to distributive organizations is much larger than the mean dollar amount of contracts awarded to local organizations (state: $2,323,515 distributive and $947,002 local; city: $438,573 distributive and $202,195 local).

In all of the analyses that follow, we consider funding to local and distributive organizations separately. The spatial distribution of the latter sort of funding is problematic, because distributive organizations by definition spend their money in neighborhoods beyond the one in which they are located (although they may also spend money in their own neighborhood). In order to better gauge how distributive organizations spend their money, we perform a separate analysis of city contracts only. The city contract data contain a field that indicates the community district in which the services were actually delivered. This improves our ability to assess where the money that is awarded to distributive organizations is actually spent, although some neighborhood variability is lost by using the larger community district boundaries. Additionally, for about 42 percent of contracts to distributive organizations, the field indicating the location of service indicates that services were provided either throughout a particular borough (hereafter “boroughwide”) or across the entire city (hereafter “citywide”). Because we have no basis for making an assumption about how these funds are distributed, and any assumption will largely drive our conclusions, the analysis below uses only the 58 percent of contracts where the data indicated to serve multiple neighborhoods. Every effort was made to utilize online information to determine whether the organization had been local or distributive at the time that the contract was allocated. This included making extensive use of organizational histories when those were available on organizational websites. A very small percentage of organizations (less than 1 percent) in the data set had no online information available. These contracts were excluded from the analysis.
cated that services were delivered in a specific community district (or districts).

**DESCRIPTIVE FINDINGS**

**ALLOCATIONS**

We calculate a measure of total funding to health areas and community districts by summing up the amount of each contract spent within the time interval for all contracts awarded to organizations within that geographic unit. At the community district level, when a contract record indicates that an organization spent that contract’s funds in multiple specific community districts, we divide funding proportionally by population size across all indicated community districts. Because both health areas and community districts vary in population size, we divide the total amount of funding over the 5-year period by five times the population size to get the average annual funding per capita.

Table 1 summarizes the four measures of funding per capita we use for our analysis. Funding per capita at the level of health areas provides us with more fine-grained detail about spatial allocation to geographic boundaries closely approximating neighborhoods but allows us to examine spatial allocation based only on the location of organizations. The community district data, on the other hand, allow us to determine more accurately how money is dispersed spatially by distributive organizations themselves because we can analyze spatial allocation based on the location of the service, although this comes at the cost of the finer detail of health areas and is only available for contracts awarded by the city. Furthermore, a substantial component of allocation at the community district level remains invisible because we have no way to evaluate the spatial allocation of contracts that were reported to be boroughwide and citywide.

<table>
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<tr>
<th>Geography</th>
<th>Type</th>
<th>Source</th>
<th>Mean</th>
<th>Median</th>
<th>IQR</th>
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<td>Local</td>
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<tr>
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<td>City + state</td>
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<tr>
<td>Community district</td>
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Note.—IQR = interquartile range.

* Distributive funding at the community district level does not include citywide and boroughwide contracts.
Over the time period of study, the average New York health area resident received about $93.00 in services from local organizations per year and about $168.00 in services from distributive organizations. The numbers are lower at the community district level because we only use city data and exclude all boroughwide and citywide funding. In every case, the medians are much smaller than the means and the interquartile ranges are quite large, indicating a high degree of inequality across neighborhoods in the amount of funds that they receive. Figure 1 shows the distribution of funding per capita to health areas by the city and state. Both distributions are heavily right skewed. The majority of health areas received small amounts of funding per capita (under $100/person) with a small minority of health areas receiving thousands of dollars per person. In terms of total funding, all health areas received some money over this time period. However, when we separate funding by service types, the majority of health areas received no funding for any given service type over the time period. Incorporating this source of spatial variability into the analysis below is a major methodological challenge.

Figure 2 shows the distribution of contract dollars across service types for the city and state. City funding is heavily concentrated in day care and family services, whereas state funding is heavily concentrated in health services. For both the city and state, the majority of funding within each service type goes to distributive organizations. The two exceptions

![Figure 1. Histogram of average annual contract dollars per capita across health areas, 1997–2001, by city and state.](image-url)
are funding for day care and elderly services, which primarily flows to local organizations. Figure 3 shows maps of New York City indicating the spatial distribution of funding per capita across health areas. This figure clearly shows a high concentration of funding in midtown and downtown Manhattan for distributive organizations and less funding outside of Manhattan (left panel), whereas the allocation of funding to local organizations is less concentrated in midtown and downtown Manhattan, but also shows a great deal of variability across health areas (right panel).

**NEED**

We calculate neighborhood characteristics for each health area and community district using Census 2000 data, and measure socioeconomic disadvantage using median household income, the poverty rate, and the unemployment rate. We also calculate the relative size of three important populations that are targeted by specific types of social services: the foreign-born population, families with children, and the population age 65 years

**FIGURE 2.** Total amount of dollars allocated to service areas in New York City, 1997–2001, separately by city and state and local/distributive organizations.
FIGURE 3. The spatial distribution of average annual funding per capita across New York health areas, separately to local and distributive organizations.
and older. Summary statistics for all of these variables are shown in table 2.

The three measures of socioeconomic disadvantage are highly collinear and preliminary analysis revealed problems of variance inflation and model estimation as a result of this collinearity. For this reason, we used factor analysis to combine these three measures into a single index of socioeconomic disadvantage. This single index explained 83 percent and 89 percent of the variation in the three variables for health areas and community districts, respectively, and the factor loading for each variable was greater than .85 in all cases. The socioeconomic disadvantage index has a mean of zero and standard deviation of one.

**TABLE 2. Summary Statistics for Neighborhood Characteristics of Health Areas and Community Districts**

<table>
<thead>
<tr>
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<th>Health Areas</th>
<th>Community Districts</th>
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<tr>
<td></td>
<td>Mean</td>
<td>Median</td>
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<tr>
<td>Total population</td>
<td>23,145</td>
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<td>Median income</td>
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<td>Poverty rate</td>
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<td>Unemployment rate</td>
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<td>Percent foreign-born</td>
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<td>Percent sixty-five and older</td>
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<tr>
<td>Percent households with children</td>
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<td>Number of neighborhoods</td>
<td>336</td>
<td>59</td>
</tr>
</tbody>
</table>

Note.—IQR = interquartile range.

and older. Summary statistics for all of these variables are shown in table 2.

The three measures of socioeconomic disadvantage are highly collinear and preliminary analysis revealed problems of variance inflation and model estimation as a result of this collinearity. For this reason, we used factor analysis to combine these three measures into a single index of socioeconomic disadvantage. This single index explained 83 percent and 89 percent of the variation in the three variables for health areas and community districts, respectively, and the factor loading for each variable was greater than .85 in all cases. The socioeconomic disadvantage index has a mean of zero and standard deviation of one.

**ASSESSING THE RELATIONSHIP BETWEEN ALLOCATION AND NEED**

**ANalytic strategy**

Our primary goal is to examine the association between funding and measures of neighborhood need. Total dollars per capita received within each health area or community district is the dependent variable for the analysis that follows, presenting two methodological challenges. First, as figure 1 shows, this variable is severely right skewed, so that some form of transformation is required to reduce the influence of extreme values. Sec-

11. We also experimented with a measure of the prevalence of single-parent households. However, this measure was highly collinear with our three measures of socioeconomic disadvantage and made model estimation difficult.
ond, when we break funding down by service type, the amount of dollars spent in a neighborhood is zero for the majority of neighborhoods for most service types. Thus, an important source of variation in funding for a particular service type is that a significant number of neighborhoods receive no funding for many service types.

Log transformation is the generally preferred method to handle right-skewed variables. However, the log transformation is undefined for zero values, and so we must consider how to treat these zero values. Dropping zero values or imputing them is not acceptable because either method would severely distort our measure of spatial variation given the large number of zero values in our dependent variables. Tobit models are sometimes used in the presence of a large number of zero values, but such models are inappropriate in our case because the assumption underlying the Tobit model that zeros are produced by an underlying latent continuous variable does not describe our data well. Furthermore, in order to log the dependent variable in a Tobit model, one must still impute a value for the zeros. Another approach is to run two separate models, one that predicts nonzero values using a binary dependent variable and a second that estimates funding given that it is nonzero. This method is also inappropriate here, because it misrepresents the process of contract allocation as a two-stage process.

We model the relationship between funding per capita and neighborhood characteristics using a poisson generalized linear model with an overdispersion parameter estimated via quasi-maximum likelihood (Woolridge 1997).\footnote{Although the poisson model is generally thought of as a model for count data, it can be used to model noncount and even noninteger data. Its primary limitation is the assumption that the variance of the dependent variable must equal its expected value. Because our data do not arise from a Poisson process, there is no reason to believe that this assumption is accurate. However, this assumption can be relaxed by the inclusion of an overdispersion parameter. An alternative approach would be to use Huber-White robust standard errors. However, this technique cannot be implemented in the models to account for spatial autocorrelation. In models without spatial autocorrelation, the robust standard errors were quite similar to those produced by accounting for overdispersion via quasi-maximum likelihood.} The poisson model has been shown to be more robust than other methods for dependent variables with skewed nonnegative distributions, such as those observed in these data (Nichols 2010).

The generalized linear model framework resolves our problem with zero values. Because we are predicting the log of the expected value of $y_i$, the model is more robust to the presence of zero values.
as a linear function of the independent variables rather than the expected value of the log of $y_i$ as would be the case for an OLS regression model with a log-transformed dependent variable, zero values for $y_i$ are not problematic for our estimation procedure. The expected value for each neighborhood is positive even if the observed value is actually zero.

Exponentiated coefficients from our models can be interpreted as the multiplicative change in expected funding per capita for a one-unit increase in the independent variable. When coefficients are small, they can be interpreted directly as the approximate percentage change in expected funding per capita for a one-unit increase in the independent variable.

The maps shown in figure 3 suggest clustering of funding across neighborhoods in close proximity. Calculation of Moran’s I, a standard measure of spatial autocorrelation, for each of our measures of funding also indicated that such spatial autocorrelation was present in the data (Bivand, Pebesma, and Gomez-Rubio 2008). We account for spatial autocorrelation between neighborhoods in our models by the use of a Gaussian variogram based on the Euclidean distance between the centroid of each neighborhood.\(^{13}\)

Our analysis proceeds in two steps. First we examine the relationship between neighborhood characteristics and our four measures of funding per capita across all service codes combined. We then estimate models for each service code in order to assess whether funding for certain types of services displays a stronger connection to neighborhood need.

RESULTS

Funding across All Service Types

Figure 4 shows the relationship between each of our measures of funding per capita and the neighborhood socioeconomic disadvantage index, based on the predicted values from poisson models (minus the intercept to aid in comparison). We focus first on the left-hand panel, which shows the relationship between funding and socioeconomic disadvantage across health areas for the city and state contracts combined. Funding to local organizations is positively associated with socioeconomic disadvantage, but fund-

\(^{13}\) This approach assumes that the spatial correlation between any two neighborhoods is equal to $\exp\left( - \frac{d}{r}\right)$, where $d$ is the Euclidean distance between the two neighborhoods and $r$ is a range parameter estimated from the model (Bivand et al. 2008).
ing to distributive organizations is negatively associated with socioeconomic disadvantage. Both coefficients are statistically distinguishable from zero (local, \( p \)-value < .001; distributive, \( p \)-value < .05). We also plot the relationship between total funding and socioeconomic disadvantage with a quadratic term to allow for nonlinearity. The two divergent relationships for local and distributive organizations combine to create a nonlinear relationship between socioeconomic disadvantage and overall funding. However, because the dollars allocated to distributive organizations exceed the dollars allocated to local organizations, the overall trend for all funding is a generally negative, albeit diminishing, relationship.

This result indicates that local organizations are more likely to be located in more disadvantaged neighborhoods and are thus at least somewhat responsive to the neediest populations. Distributive organizations, on the other hand, tend to be located in more advantaged neighborhoods. The overall negative effect is largely driven by the heavy concentration of distributive organizations in midtown and lower Manhattan. When Manhattan health areas are excluded from the model the effect is very close to zero (\( b = .003 \)).

However, it may be that while distributive organizations are located in the most advantaged neighborhoods, they do as well or better at distribut-
ing services to needy neighborhoods as do local organizations. The right-hand panel thus examines the community district data on the location of service for the city contracts. For local organizations, we observe a very similar positive relationship between this measure of funding per capita and socioeconomic disadvantage, and also see a similar positive relationship for this measure of funding to distributive organizations, albeit with citywide and boroughwide contracts removed. Both of these effects are statistically distinguishable from zero ($p$-value < .05) and statistically indistinguishable from one another. These results suggest that in terms of the location of services, funding to both local and distributive organizations is positively associated with socioeconomic need.

Table 3 shows models that add variables on the relative size of targeted populations. As in figure 4, we find a positive association between the disadvantage index and three of the four measures of allocation. For distributive funding by health area, the association is no longer negative but remains effectively zero. The results for the targeted populations vary in size but are consistently negative across all three populations and all four measures of funding per capita. Increases in the population share of the foreign-born population, the elderly population, and families with children are associated with reduced funding per capita to neighborhoods for services targeted to those populations, holding socioeconomic disadvantage constant. Although

### Table 3. Estimated Parameters from Poisson Models Predicting Average Annual Local and Distributive Funding per Capita to Health Areas and Community Districts by Neighborhood Characteristics, New York City, 1997–2001

<table>
<thead>
<tr>
<th>Variable</th>
<th>Health Area</th>
<th>Community Districts</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Local</td>
<td>Distributive</td>
</tr>
<tr>
<td>Disadvantage index</td>
<td>.472***</td>
<td>.081</td>
<td></td>
<td>.538***</td>
</tr>
<tr>
<td></td>
<td>(.128)</td>
<td>(.226)</td>
<td></td>
<td>(.136)</td>
</tr>
<tr>
<td>Percentage foreign-born</td>
<td>-.015*</td>
<td>-.019</td>
<td></td>
<td>-.028**</td>
</tr>
<tr>
<td></td>
<td>(.008)</td>
<td>(.014)</td>
<td></td>
<td>(.010)</td>
</tr>
<tr>
<td>Percentage age 65 and over</td>
<td>-.052**</td>
<td>-.089**</td>
<td></td>
<td>-.044</td>
</tr>
<tr>
<td></td>
<td>(.028)</td>
<td>(.031)</td>
<td></td>
<td>(.039)</td>
</tr>
<tr>
<td>Percentage of households with children</td>
<td>-.033**</td>
<td>-.101***</td>
<td></td>
<td>-.044***</td>
</tr>
<tr>
<td></td>
<td>(.011)</td>
<td>(.017)</td>
<td></td>
<td>(.012)</td>
</tr>
<tr>
<td>N</td>
<td>336</td>
<td>336</td>
<td>59</td>
<td>59</td>
</tr>
</tbody>
</table>

Note.—Standard errors in parentheses. All models include parameters for overdispersion and spatial autocorrelation.

a Distributive funding at the community district level does not include citywide and boroughwide contracts.

* $p < .10$.

** $p < .05$.

*** $p < .01$.

**** $p < .001$. 
the analyses are not shown, these negative results hold even without socioeconomic disadvantage included as a control. Thus, while some evidence suggests a positive match between socioeconomic need and the spatial allocation of services, other evidence suggests a mismatch between the spatial allocation of overall funding and particular populations that have a higher need for specific kinds of services. However, it may still be the case that these populations receive more funding for particular services that are relevant to their needs.

**Funding within Service Types**

We now move to models estimated separately for each service type. Figure 5 shows the regression coefficient measuring changes in the log of expected funding by socioeconomic disadvantage for each service type. The panel on the left is based on the health area where the organization is located and the panel on the right is based on the community district where the service is provided.

For health areas, the difference between distributive and local organizations found above is replicated across almost all service types. Every coefficient is negative for distributive organizations, while almost all of the coefficients are positive for local organizations. Within each organization
type, there is some variability in the size of the coefficient, but the striking feature is the consistency of positive and negative effects for local and distributive organizations, respectively. Thus, for all service types, distributive organizations tend to be located in more socioeconomically advantaged neighborhoods and for almost all service types, local organizations tend to be located in more socioeconomically disadvantaged neighborhoods.

The results for the right panel, which looks at the community district where services are delivered, are more mixed. For both local and distributive organizations, some associations are positive and some are negative and the results are not consistently higher for local organizations.

To examine the relationship between funding for specific service types and the prevalence of the population targeted by those services within a neighborhood, we select four service types that should be tied to these particular demographic groups: for the foreign-born population, funding for immigration-related services; for the elderly population, funding for elderly services; and for families with children, funding for family services and day care, separately. For each of these service types, we run a model that includes both the disadvantage index, the relative size of the demographic group that those services should be targeting, and the interaction between these two variables. The main effect of the relative size of the group indicates the extent to which funding increases with the prevalence of the targeted population when the neighborhood is at a citywide average level of disadvantage. The interaction term indicates whether more or less funding is allocated to those targeted populations as neighborhood disadvantage increases or decreases. Table 4 shows the results of these models, which indicate a relatively weak association between the allocation of funding and the concentration of populations in need of specific services. For immigration and elderly services, the results suggest that funding to local organizations is more likely to flow to the targeted populations (immigrants and the elderly, respectively). For the funding of elderly services, this targeted allocation toward the elderly increases with the level of disadvantage in the neighborhood as indicated by the substantial and statistically significant positive interaction term, but the same does not appear to be true for the funding of immigrant services toward immigrants. Neither of these findings holds for distributive funding, even when analyzed by the location of services at the community district level. In fact, in clear contrast to the finding for local organizations, the funding for elderly services seems to be allocated away from the poorest elderly, as indicated by the
substantial and statistically significant negative interaction term at the community district level.

For both day care and family services, we find evidence that funding is actually less likely to be allocated in neighborhoods with a high prevalence of families with children than in neighborhoods with a low prevalence of these families. There is little evidence that this negative targeting changes...
with the level of disadvantage in the neighborhood and what evidence there is, actually suggests a negative association (local organizations by health area) such that money is least likely to go to areas with a high concentration of poor families. Thus, there seems to be a clear mismatch in the allocation of funds for social services targeted to families with children and the spatial concentration of those families.

**DISCUSSION AND CONCLUSION**

The privatized delivery of most publicly supported social services makes the variable allocation of funding for services across geographic space an important question for public policy. The foregoing analysis takes an important step in furthering understanding of the availability of these services, which are a key piece of the contemporary welfare state, particularly for our lowest-income citizens. We improve upon prior studies that examine the location of nonprofit organizations in relation to lower-income areas by tracking the actual dollars present in needy neighborhoods, and thereby provide a stronger assessment of resource availability in the zero-sum game of service allocation across the city’s geography. Needy citizens who reside in neighborhoods with fewer dollars available to support key social services have more limited opportunities to improve their current conditions and life chances than equally needy citizens who live in better-resourced neighborhoods. This study aims to understand the extent of this inequality.

The data offer a unique resource for tracking the distribution of government contract dollars for social services across neighborhoods in New York City. At the same time, there are some limitations to our ability to understand the specific location where those dollars actually produce services. The address field for each contract indicates a single location for the contract recipient. For organizations that operate multiple service locations, it is not clear whether the address information accurately reflects the location where the specific contract supports services. In this article we adopted two approaches to explicate this issue. First, we categorize all contract recipient organizations as either local (i.e., they deliver services in their immediate area) or distributive (i.e., they deliver services at multiple locations). This distinction allows us to understand which contracts are most clearly tied to specific locations (the contracts going to local organizations), while separating out the contracts that need further examination to make a loca-
tional attribution (the contracts going to distributive organizations). Second, we use a data field with additional locational information to examine contracts to distributive organizations, allowing us to determine, at the community district level, where services paid for with contracts to distributive organizations were actually delivered. While this information is only available for the contracts from New York City government, and specific community districts are identified for only 58 percent of the distributive organization contracts, this information strengthened the accuracy of our analysis.

For both local and distributive organizations, we examine the spatial match between neighborhood need and the allocation of contract dollars in two ways. First, we analyze the distribution of total funding for all service types to neighborhoods. Second, we examine how funding for four specific types of services—immigrant services, elderly services, day care, and family services—are matched to neighborhoods with populations most likely to make use of such services—the foreign-born, the elderly, and families with children.

We find that when the city and state allocate funds to local organizations, there is a positive and substantively strong relationship between the total amount of social services dollars distributed to neighborhoods and neighborhood disadvantage. In other words, when considering organizations that serve their immediate neighborhoods, the city and state do distribute the total package of contract dollars to the neighborhoods in greatest need. For funding allocated to distributive organizations, however, there is a negative relationship between the neighborhoods where the central offices of those organizations are located, and neighborhood disadvantage. This is largely because so many distributive organization headquarters are located in downtown and midtown Manhattan, which tend to be higher-income areas.

For the subset of contracts where we have available information on the community district where the service was provided, however, the data suggest that contract allocations to both local and distributive organizations are positively associated with neighborhood disadvantage. This suggests that the internal allocation processes of distributive organizations are roughly as efficient at getting money to needy populations as is the city government’s own allocation process to local organizations. However, this latter analysis includes only the city data, and excludes the roughly 42 percent of city funding to distributive organizations that was classified
as boroughwide or citywide. Indeed, combining these location-unknown city contracts with all of the state contracts to distributive organizations (none of which had location information), there is a large black box in our understanding of where contracts allocated to distributive organizations actually end up making services available.

Analysts, practitioners, and government officials could all benefit from further research on this question, as there may be good reason to suspect that public dollars that go to distributive organizations are not flowing as efficiently to needy populations as are funds that go to local organizations. At the very least, the central offices of distributive organizations are much less likely to be physically located in the neediest neighborhoods than are local organizations. While public transit is widely available in New York City, there is certainly inequality in transit access, particularly for neighborhoods that are located far from the Manhattan sites where most distributive organizations are headquartered.14

The second set of analyses examined the allocation of contracts for specific types of services, paying particular attention to services that have clearly identifiable target populations. Across all service types, we find a pattern quite similar to that for our previous analysis of overall funding. That is, when looking at the location of the organization, allocation to local organizations is generally positively associated with disadvantage, while allocation to distributive organizations is generally negatively associated with disadvantage. When we analyze the subset of the data for which we have information on the location of the service, however, the advantage of sending contracts to local organizations is much less clear.

More importantly, however, the results for specific targeted populations reveal a relatively weak spatial match, and in some cases a spatial mismatch, between funding for specific service types and the prevalence of targeted populations. There is some evidence that local organizations are better at allocating funding toward more disadvantaged elderly and immigrant populations than distributive organizations, but both local and

14. Some distributive organizations have satellite locations in neighborhoods other than their headquarters location, while others do not. It is not possible to determine from our data whether the service delivery location of a distributive organization represents a satellite location or some other form of decentralized service provision (e.g., subcontract to another service provider, temporary partnership with a government agency, or other private organization).
distributive organizations do a poor job of targeting families with children. Both day-care and family services funding are negatively associated with the concentration of families with children, and this result varies little by the overall level of neighborhood disadvantage. Further research on why day-care and family services funding are so poorly matched to need might consider whether day-care organizations in particular might be located in more commercial areas, that is, closer to parents’ workplaces rather than their residences.

Our analysis suggests that the process of government contracting to nonprofit organizations raises several important public policy issues. The first is whether privatizing social services adequately provides needy citizens with access to potentially beneficial assistance. Our study of New York City offers mixed evidence for a positive association between contract dollars available and levels of general and specific need, suggesting that there is room for improvement both in the tracking of where distributive organizations make their services available, and in the matching of government funds to neighborhoods and populations of need.

Second, our analysis points to the importance of understanding the internal allocation processes undertaken by the nonprofit organizations we refer to as distributive. Again, better tracking in the data of where contract dollars to distributive organizations end up seems indicated. In addition, further research seems warranted on whether and how government agencies might attempt to constrain distributive organizations’ use of specific contracts to target disadvantaged neighborhoods or populations.

Third, our finding that contracts to local organizations most consistently (though not always) match up with neighborhood disadvantage reinforces the important role that locally based, community-focused nonprofits play in poor places (cf. Marwell 2004, 2007). Whether this relationship remains true over an extended period of time is an important question, as is tracking the relative size of the segments of the nonprofit organizational population that are of the local as opposed to the distributive type. Both of these issues are likely to affect how accessible publicly supported social services are to needy individuals, families, and communities.

Finally, while this study shows that need is partially driving the allocation of social services contracts, the results are not conclusive. There are other factors that may drive the variation in contract dollars across neighborhoods, for instance the quality of an organization’s services. While
ideally public funds are spent on high-quality services, it seems likely that service quality is unequally distributed across organizations, and thus across neighborhoods. If the contract allocation process prefers the highest quality organizations, this preference may well exacerbate the spatial mismatch between service availability and need. Government agencies currently emphasizing performance measures of service quality would do well to anticipate this unintended consequence.

In addition, some service-providing organizations may choose not to locate themselves in the most disadvantaged areas, which may affect whether residents of high-need neighborhoods have equitable access to sites of service provision. Certainly the data show that distributive organizations, which receive a larger share of total contract dollars, and have contracts of larger average size compared to local organizations, are concentrated in better-off sections of Manhattan. Again, how well distributive organizations are able to provide service sites in poorer areas will affect service access for needy individuals, families, and communities. While our analysis shows that distributive organizations do as well as local organizations in targeting overall disadvantage, neither type of organization matches specific services (such as day care or elderly services) well with those services’ targeted populations. These issues are especially important for distributive organizations since they receive a majority of total contract dollars.

A third potential factor driving the distribution of contracts may be political influence. As the first author (Marwell 2004) shows, local elected officials acting in concert with nonprofit organizations in their districts can exercise important influence over the contract allocation process. While political influence over contracting sometimes is plainly corruption, she argues that the “new machine politics” (278) can also be understood as a form of legitimate political organizing that seeks to influence our complicated present-day mechanisms for distributing public resources. Of course, the fixed sum available for social services contracts means that one organization’s ability to influence allocations in its favor is another organization’s loss. The importance of social services in the social benefit package of our poorest citizens led us to examine the relationship between the allocation of social service funding and community need, and we hope that future research will deepen understanding of how the distribution of scarce public resources affects different dynamics important to the lives of the poor.
NOTE

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