A STUDY TO DETERMINE THE BEST SOURCES OF FUNDING FOR A FAMILY PRACTICE RESIDENCY PROGRAM AT LUTHERAN GENERAL HOSPITAL, SAN ANTONIO, TEXAS

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CHAPTER I

INTRODUCTION

General Information

A host of individual authors as well as public and private commissions has, over the last five to seven years, traced the decline of the general practitioner and the national widespread yearning for more personal medical care in an age of rapidly advancing technology and societal unrest.[1]

Anne Somers believes the ideal of the old time, small town, family doctor is more a myth than fact, but she does feel that the desire of people for a personal physician is a legitimate demand.[2] A number of the commissions have reviewed the American health care field, and, as early as 1966, they identified a need for comprehensive or family-oriented health care which would fulfill this desire for more personal health care.[3] In December, 1968, the House of Delegates of the American Medical Association approved a set of Essentials for Residency Training in Family Practice, and, in April, 1969, the American Academy of General Practice published an official guide to the requirements for the establishment and the operation of an approved family practice residency program.[4] By the opening of the 1970-1971 residency year,

forty-six programs had been approved in the United States with 286 students enrolled in the programs.[5] As of October, 1971, a total of fifty-nine programs had been approved.[6]

These family physicians are being trained to fulfill four very broad general functions. According to the Commission on Education of the American Academy of General Practice, these functions are: (1) to be the first medical contact for patients to facilitate their access to the whole health care system; (2) to serve as the key to the referral process for problems beyond the family physician's scope of practice and competence; (3) to serve as the integrater of all health services received by his patients; and (4) to insure continuity and comprehensiveness of medical care.[7]

These primary physicians or family practitioners are needed in all areas of society, but nowhere is the need greater that in the ethnic and socioeconomic ghettos of the metropolitan areas of the United States.[8] Thus, attempts must be made to train these family practitioners in those areas in which their particular skills are most needed today.

This need for a more personal physician along with the more acute need for a real health care system within the urban ghettos must, of course, compete for scarce health care resources against all other health care needs. One only need look to the current average

stipends of interns and residents to demonstrate the increasing cost of graduate medical education.[9] An administrator who desires to have his hospital contribute to the local community by way of establishing a family practice residency program must carefully consider the cost of the medical education program before he commits his hospital to this laudatory endeavor.

History of Lutheran General Hospital[10]

The Grace Lutheran Sanatorium was officially opened on September 13, 1913, as an act of civic charity on the part of the Grace Lutheran Church of San Antonio, Texas. The sanatorium was established to treat and care for tubercular and other long-term type patients, and it has always accepted patients regardless of their religious affiliation.

During the early years of its existence, the growth of the institute was slow, and, in fact, it was not until the 1940's that a chapel was added to the sanatorium complex. However, it was during these early years that thirty-one cottages of a distinctive Old Spanish design were built to replace the tents originally used to house patients. These cottages are still in use for some minimal care patients, and they give the hospital grounds a novel and beautiful atmosphere of the less hectic days of yore which San Antonio and the hospital once

enjoyed.

In 1957, an extensive expansion of the physical plant was begun. In that year, sixty-three beds were added to the original fifty-six. In 1959, forty-eight more beds were added to provide a geriatric service to the hospital.

In 1964, the Grace Lutheran Sanatorium and Hospital began an extensive reorganization with the hope of obtaining accreditation by the Joint Commission on Accreditation of Hospitals. By 1965, the medical staff had been reorganized, and the word sanatorium was dropped from the title of the institution so that it was called Grace Lutheran Hospital.

In January, 1967, the Herman and Lena Ocks Center was added to the hospital physical plant. This center included forty-four beds and two operating suites. With the addition of the center, the transformation of the original sanatorium into a modern community general hospital was complete. In recognition of this fact, the name of the institution was again changed on May 8, 1967, to Lutheran General Hospital.

The hospital, located at 701 South Zarzamora Street on the near West Side of San Antonio, is a fully accredited 200-bed short-term general hospital providing general medical, general surgical, obstetrical, pediatric, and limited psychiatric care to a wide variety

of patients. The hospital is controlled by a board of directors elected by the board of trustees of the Southern District of the American Lutheran Church.

Conditions Which Prompted the Study

As Lutheran General Hospital has evolved into a community general hospital, a growing sense of concern for local neighborhood problems has also developed. The hospital, located in the center of the Model Cities area of San Antonio, is in an excellent location to provide primary health care to a population much in need of these services.[11] Thus, members of the medical staff of the hospital, hoping to be able to provide much needed health care to the community and seeing the opportunity to help train young physicians in a new area of medicine, requested that the administrator of Lutheran General Hospital, Henry J. Rockstroh, investigate the possibility of establishing a family practice residency program at Lutheran General Hospital. From the beginning, the program was envisioned as a means of providing much needed comprehensive family-oriented health services to the members of the local community and also as a channel for providing excellent family practice training of well-qualified medical school graduates under the direct supervision of experienced family practitioners who are members of the active medical staff of the hospital..

By early 1971, it had been determined that the professional

personnel were available to meet the criteria of the American Academy of Family Practice for the establishment of an approved residency program.[12] At the same time, it became apparent to Mr. Rockstroh that the only problem which would stand in the way of the program was the lack of funds to establish and operate the program.

Later in 1971, the problem of determining appropriate sources of funding for the program was submitted to the United States Army-Baylor University Program in Health Care Administration as a proposed research problem. In February, 1972, the writer visited the hospital and determined that the hospital was actively seeking formal approval of the family practice residency program from the American Academy of General Practice and that cost estimates for the first three years of the program had been developed by the hospital. As of that time, no source of funding for the program, tentatively scheduled to begin operation on July 1, 1972, contingent upon the formal approval of the program, had been determined by the hospital.

Statement of the Problem

The problem is to determine the best sources of funding for a family practice residency program at Lutheran General Hospital, San Antonio, Texas.

Objectives

There are two general objectives which must be accomplished in order to solve the stated problem. These objectives are:

1. To identify and define the major sources of funds which may be used to finance a graduate medical education program.

2. To analyze and contrast the alternate sources of funding available to Lutheran General Hospital and to compare the advantages and the disadvantages of using the different sources of funds to finance the graduate medical education program at Lutheran General Hospital.

Criteria

Any solution to the stated problem must meet the following general standards before it can be considered the best source of funds for the family practice residency program at Lutheran General Hospital:

1. The source of funds must be one which is consistent with the standards established by the American Medical Association and the American Academy of General Practice for funding of family practice residency programs.[13]

2. The source of funds must be acceptable to Lutheran General Hospital, its organized medical staff, and the patients of the hospital on moral, ethical, and legal grounds.

Limitations

The following limitation has been imposed on this study: The administrator of Lutheran General Hospital stated that any solution to the cited problem must provide a guaranteed source of funding for the full amount of funds needed for one complete residency class before the family practice residency program can be put into operation. Thus, the hospital feels it must be able to guarantee any resident who enters the program in its first year that he will graduate from the program at Lutheran General Hospital.

Assumptions

The following assumptions have been made for the purpose of this study:

1. The Bexar County Hospital Tax District will continue to be the sole provider of local tax-supported medical care to local residents.

2. The American Lutheran Church will not provide any funding to Lutheran General Hospital for any purpose.

3. Lutheran General Hospital will accept and meet any requirements imposed by an acceptable outside source of funds which may be conditional to receiving funds.

4. A national health insurance program guaranteeing provider payment for care will not be passed before July 1, 1973.

Factors Bearing on the Problem

Certain factors exist which bear directly upon the problem of obtaining funding for a graduate medical education program. These factors are wide ranging and must be discussed at least briefly before going further. Some factors are outside the direct scope of this study, but, because they influence the problem at Lutheran General Hospital, they are also examined.

The first of these factors is the hospital itself. Lutheran General Hospital has been a full-service general hospital only since 1967. Thus, even though the hospital has a long history of being located at its present address, no real neighborhood health service tradition exists. The hospital has not been involved in any Model Cities projects to date, and it would take a long period of time and a great deal of effort to have the hospital identified with the local community. Thus, federal funding under any Model Cities legislation is not available to the hospital at this time.

Another internal factor is that, at present, no graduate medical education program exists at Lutheran General Hospital. The family practice residency program has been Lutheran General Hospital's only attempt to enter into graduate training of physicians. Thus, the possibility to "bleed off" aid in funding from other, more established residency programs does not exist at this hospital. The

family practice residency will be a full added cost to the hospital less any income the program can generate.

Lutheran General Hospital has a high percentage of Medicare and Medicaid patients. At present, 63 per cent of all patients are on Medicare and Medicaid, for whom reimbursements are tightly controlled by federal regulations.[14] This leaves the hospital with a relatively small percentage of patients who either pay their own hospital bills or who have private third-party payers. It could be expected that the family practice residency program would generate the same relative mix of patients.

Lastly, the active medical staff of Lutheran General Hospital is composed of approximately eighty-five physicians, the majority of which are general practitioners, most of whom are independent, fee-for-service private physicians. The medical staff is strongly disposed to a fee-for-service family practice residency program, at least once the program is in operation.

Factors exist outside the local institution which affect the problem also. It must be noted that the family practice residency program is the newest of the medical specialties and not all physicians are in agreement that the program is viable.[15] Thus, there has been a reluctance in some quarters to provide funds directly for family practice residency programs.[16] Another factor is the increasing cost

of all graduate medical education. Salaries of interns and residents alone have risen sharply over the past few years.[17] The director of medical education must be hired and paid by the hospital. Lastly, the "hidden costs" of graduate medical education such as equipment and supplies required to support the program will serve to increase further the financial burden.[18]

The sources of funds available in general to fund graduate medical education will affect this problem. These funds can be obtained from (1) patient charges, to include Medicare, Medicaid, all private third-party payers, and direct pay patients; (2) direct government funding, to include local, state, and federal sources; (3) philanthropy, to include local and national sources; (4) assessments levied on the attending staff; and (5) private financing, to include all forms of debt financing such as loans, bonds, and long-term debts.[19]

Another factor is that the family practice residency program requires that the resident spend at least part of his time seeing and treating outpatients. Most medical reimbursement programs such as Medicare and the vast majority of private third-party payers do not cover routine outpatient care.[20] Thus, this outpatient service will represent a potentially high no-pay risk area for generating operating losses to the hospital if it is not accounted for in developing the

organization and in operation of the family practice residency program.

Moral, ethical, and legal factors bear directly upon the problem. If patient charges are to be increased, then the burden of education will be shifted to all or part of the inpatients of Lutheran General Hospital. Is it proper that patients be made to pay for medical education, or should the cost be spread to a larger population? If federal funds were accepted, certain legal requirements as to the types of patient who could be treated would be imposed by federal regulations. Would these requirements be acceptable to the hospital and its medical staff?

Research Methodology

Three methods of research were used in solving the stated problem. An extensive review of hospital literature was made to determine the current state of graduate medical education and the generally accepted sources of funding for these programs. Personal interviews were conducted with persons in authority at Lutheran General Hospital to determine the scope of the problem and those limitations and factors which affect the problem as it exists at Lutheran General Hospital. Financial and statistical documents on file at Lutheran General Hospital were examined and collected as supporting evidence for interviews and to provide additional local information of a historical nature.

A personal interview was conducted with the administrator of Lutheran General Hospital to obtain his views relating to the stated problem and to receive any guidance he had regarding the problem. The assistant administrator in charge of Administrative and Fiscal Services was personally interviewed to determine the current financial status of Lutheran General Hospital and the funding possibilities for the family practice residency program as he envisioned them. The development director, who is in charge of obtaining donations and gifts for the hospital, was personally interviewed by the writer to determine the nature and the extent of the development program at Lutheran General Hospital. The director of medical education was interviewed to obtain information on the family practice residency program and what the desires of the medical staff would be with respect to the program.

A small sample of private national foundations were contacted by way of personnel interview and written correspondence to determine their willingness to consider a funding request from Lutheran General Hospital.

The information gained from personal interviews was compared with and cross-checked against the pertinent data gleaned from the hospital literature. Historical patient statistical data and financial data collected from the hospital records were accepted as valid, and,

where the validity of data was questionable, this was noted by the writer in the study. Data taken from literature reviews have been used only in those cases in which at least three sources were found in agreement.

The data collected from personal interviews and literature review will be analyzed and contrasted in light of the criteria and the limitation imposed on the problem. Thus, alternative methods of dealing with the program will be examined in order to arrive at the solution to the stated problem.

Literature Review

As has been noted by any number of authors and commissions in the recent past, there has been a growing realization that the family physician capable of providing or obtaining comprehensive health care for his patients is sadly lacking in the United States today.[21] As one commission noted, "the rise in specialization has been accomplished by an alarming decline in the number of physicians who devote themselves to continuing and comprehensive care of the whole individual."[22] Still another commission found the answer to this problem in the establishment of a new specialty in medicine which could provide these services to patients.[23] Other authors have recognized the need for the family physician and have urged the establishment of a graduate medical program

to produce physicians with the requisite skills.[24] In December, 1966, the American Medical Association House of Delegates approved the Essentials for Residency Training in Family Practice, and, in February, 1969, the American Board of Family Practice was established to provide board certification for family practitioners.[25]

It is perhaps unfortunate that the newest specialty in medicine should come upon the scene at the same time as all medical education and, in particular, graduate medical education is undergoing vast changes, not the least of which is the ever-increasing cost of medical education. That this is a complex and confusion field is cliché. As Ebert points out, "It has been stated repeatedly that it is impossible to dissect the precise amount of time allocated to teaching from that concerned with patient care."[26]

Helgeson, at the Methodist Hospital of Dallas, Texas, in 1969 showed that a full 10 per cent of that hospital's gross charges to patients was the known cost of the graduate medical education program at the institution.[27] Fein and Weber point out that some studies at medical centers have shown that "average operating costs related to intern and resident education (based on medical school faculty effort allocation) were between $5,300 and $9,100 per intern and resident." These same authors state that, "In 1965-66, the mean stipend for interns was about

$3,800. Two years later it has risen to $4,950. During the same period the mean annual stipend for first-year residents rose from $3,930 to $5,040.[28] More recent data for the years 1970-1971 indicate that stipends for interns rose to $8,115 and for 1st-year residents to $8,759.[29]

All of these indicators point to ever-increasing costs of graduate medical education. These increasing costs must be covered by increasing the funding program. This is particularly true in a new program. As McNulty has pointed out, the cost of any program, and, in particular, of those which reach outside the hospital, is very expensive.[30]

Funding of hospitals has always been a difficult problem. As Hahn has stated, "historically, hospitals have obtained their capital primarily through philanthropy and government." Philanthropy provided operating funds while government funds provided for hospital construction. He also has noted that, even at the peak, the Hill-Burton program provided less than "15 per cent of construction funds in the private sector."[31] Smith has shown that philanthropy is still an important source of funds for hospitals. He points out that "total donations to all not-for-profit organizations in 1970 reached a record $19 billion--5 percent (sic) more than in 1969."[32] However, Hahn has shown that philanthropy, while increasing in absolute amount, has

contributed proportionately less to hospital capital funding because of the increases in hospital capital needs. He also points out that philanthropy varies from one region to another in the United States. In particular, he states that "philanthropy is a greater source of capital in the East than it is in the West."[33]

Third-party payers, both private and public, have had profound effects upon hospital funding. As Hahn pointed out, "third-party payers have reduced the number of no pay patients."[34] These third-party payers have smoothed the cash flow of hospitals and thus have, on the whole, aided the hospital in the financial field. However, as Walls has pointed out, "in the process of paying for as much as 90% (sic) of all hospital care in the United States, they have caused an ever increasing financial problem by going increasingly to reimbursement for care based on cost of that care."[35] Medicare has been a prime mover behind this move to reimbursement for cost of care, and a bitter debate fills the hospital literature today over the propriety of this formula.[36]

Walls sees the decline of direct government grants as a source of funds for private not-for-profit hospitals. As stated above, Hill-Burton funds were but a small part of all hospital funds, and, as Walls states, state and local funds are going "almost exclusively to public institutions."[37] Even where government funds are available, the use

of federal funds under existing programs is difficult, at best. Blendon and Gaus found it all but impossible to undertake innovations in providing health care to poverty groups since "each patient had to meet at least four different criteria of eligibility before the care could be delivered." They finally laid the blame to the "sickness of government."[38]

Reed has pointed to the possibility of financing hospital needs by the use of tax-exempt bonds issued by a duly constituted authority or by a political unit with only the revenue of the facility as security.[39] This may work well in the future for construction funds and purchasing of fixed assets, but hospitals have not, at least up until now, been willing to borrow operating funds where the cost of borrowing would have to be passed on to the patient.[40]

A number of attempts have been made to fund graduate medical education by using various types of group practice organization. Phillips and Holler, reporting on a family practice residency program in which fifteen residents and their instructors were involved in a fee-for-service group practice, stated that fees generated from private practice had been able to support 40 per cent of the cost of the program.[41] The University of Southern Alabama is developing a program to combine comprehensive group medical practice with use of the group as a training area for family physicians. The plan would be prepaid, with about 5,000 students and the faculty of the university as members.[42] Many

operating programs in family practice residency, as outlined by the American Academy of General Practice, include fee-for-service at least as part of the funding for these programs.[43]

Thus, it has been shown that patients, third-party payers, all levels of government, private philanthropy, and private commercial debt financing have all been used as sources of funds to enable hospitals to obtain funds. This study will determine the best sources of funding for the family practice residency program at Lutheran General Hospital, San Antonio, Texas.

Footnotes

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[19]Fein and Weber, p. 123; Richard W. Reed, "Avenues to Funding," Hospitals, XLVI (March 1, 1972), 182.

[20]Somers, Health Care in Transition, p. 48.

[21]Ibid., p. 18; Gerber, p. 19; Citizens Commission on Graduate Medical Education, p. 18; National Commission on Community Health Services, pp. 203-4; and Reader and Goss, p. 282.

[22]Citizens Commission on Graduate Medical Education, p. 15.

[23]National Commission on Community Health Services, pp. 203-4; and Reader and Goss, p. 282.

[24]John Fry, Medicine in Three Societies (New York: American Elsevier Publishing Co., Inc. 1969), p. 99; and Somers, Health Care in Transition, p. 90.

[25]Commission on Education, pp. 16, 132-B.

[26]Ebert, "New Methods of Financing," p. 112.

[27]James G. Helgeson, "A Study to Determine the Best Method by Which to Finance Graduate Medical Education at Methodist Hospital of Dallas, Texas" (unpublished Master's thesis, Baylor University, 1969), p. 47.

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[32]Raleigh L. Smith, "Is Philanthropy Dead?" Hospitals, XLVI (March 1, 1972), 96.

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CHAPTER II

DISCUSSION

The Problem As It Exists At Lutheran General Hospital

Lutheran General Hospital has had no real experience with any type of graduate medical education program. The hospital and its medical staff do have a true desire to provide health care service to the immediate Model Cities neighborhood and the general local population of San Antonio, Texas.[1] The physicians of the hospital are eager to provide instructions in family medicine to qualified medical school graduates.[2] However, the hospital has had to develop the family practice residency program with a minimum of actual historical data available upon which they could base the program.

The hospital does have the five inpatient services which are required for the family practice residency program. These services are: (1) medicine; (2) pediatrics; (3) surgery; (4) obstetrics-gynecology; and (5) psychiatry.[3] However, the hospital does not operate a regularly organized outpatient department.[4] The community medicine or outpatient care aspects of the family practice residency program must be completely developed from the ground up. This community medicine aspect of the family

practice residency program is most important since it requires that the family practice residency program provide time on a daily basis for the resident to practice in a family practice or outpatient environment.[5] It should be realized that a certain number of patients seen in this outpatient context will not be admitted to the hospital and, thus, will not be subject to routine inpatient billing. The cost of care and the billing of these outpatients are not problems which Lutheran General Hospital has had to address up until now.

Over the last two hospital fiscal years, the hospital has had a net gain in income (see Appendix B). However, the hospital would not have been able to reach this status if the development program had not added a relatively substantial amount to offset expenses in patient care, equipment purchase, and payment of past debts (see Appendix C).

Lutheran General Hospital has a full-time development director who operates directly under the administrator (see Appendix D). The development program includes: (1) a direct mailing list of 557 names of "friends of the hospital" which is used for a quarterly mailing to seek contributions to a variety of hospital programs; (2) the Christmas Seal Program used for "charity" patients; and (3) a few individual requests to local foundations and estates for monetary support for special projects. These requests tend to be on a personal one-to-one basis between the

development director and appropriate individuals concerned.[6] During the calendar years of 1969 through 1971, the development program at Lutheran General Hospital has generated a sizable amount of gifts and donations (see Appendix C).

Lutheran General Hospital has a great number of Medicare and Medicaid patients. The percentage of all inpatient admissions in this category has been increasing since 1967. During 1971, 63 per cent of the 6,778 admissions were Medicare and Medicaid patients (see Appendix E). The number of patients who could be expected to seek care from the family practice residency program at Lutheran General Hospital would most probably closely parallel the types of patients now being treated at the hospital.[7] This could result in the family practice residency program having a large part of its population unable to pay outpatient fees. These patients would most likely be covered for care by Medicare and Medicaid. However, these programs provide only limited outpatient coverage, whereas the family practice residency program is being based upon comprehensive and continuous medical care. The distinct outpatient orientation of the family practice residency may create funding problems which are not normally found in other graduate medical education programs.

Lutheran General Hospital has no physicians on its payroll. The full-time pathologist and radiologist who work in the hospital work

on a fee-for-service basis and provide a separate bill to the patients who use their services.[8] The hospital plans to obtain qualified instructors for the required teaching areas from active and honorary staffs of the hospital. Mr. Rockstroh, the administrator, has indicated that the voluntary services of an adequate number of qualified specialists have been obtained to begin operating the family practice residency program.[9] However, it must be noted that the arrangement would be voluntary on the part of the teaching physicians and it could be terminated at any time by any teaching physician who decided that he did not care for the program or some certain aspect of the program.

The hospital has developed a proposed budget (see Appendix F) for the first three years of the family practice residency program. The proposed budget does not include any increase in the number of residents in the program after the first year. This technically fulfills the limitations established by the administrator in planning for one full residency cycle, but it should be clear that, if the program is at all successful in its first year, the second and the third years are underbudgeted by at least the salaries of any additional residents that are brought into the program after the first year. At the budgeted $12,000 per year per resident, this could add a sizable amount to the proposed budget for year two and year three.

Alternative Solutions to the Problem

General

The alternate solutions to this problem must satisfy the criteria as outlined above and the limitations established by the administrator of the hospital while, at the same time, taking advantage of the particular strengths of Lutheran General Hospital (refer to Chapter I, p. 7). A variety of factors affect each of the possible alternative solutions to the stated problem. Each of these factors will be discussed so that the best alternative can be selected.

As stated above (refer to Chapter I, p. 11), there are five ways in which graduate medical education has been funded in the United States. These sources of funds are: (1) increased patient charges; (2) direct government funding to include local, state, and federal government programs; (3) philanthropy; (4) assessment levied on the attending staff;[10] and (5) private financing to include all forms of debt financing.[11]

In the opinion of the writer, any of these alternative sources of funds could be used to fund the family practice residency program at Lutheran General Hospital. However, the central question is to determine the best source of funds for the program which will (1) guarantee funding for at least one full residency cycle; and (2) be acceptable as a source of funds to the hospital, the medical staff, and

the patients who do and who will be using Lutheran General Hospital

Alternative One

Alternative One is to increase patient charges of all inpatients to cover the cost of the family practice residency program. This solution would include several diverse sources of funds under the one general solution. Increased inpatient charges would include higher payments from direct pay patients who pay their own hospital bills and also those who depend upon third-party payers, both governmental and private. It should be recognized that Medicare and Medicaid will pay a flat per patient pay assessment if the assessment is levied against all inpatients of the hospital and Medicare and Medicaid patients are receiving benefits from the program.[12] This solution would, of course, have the greatest impact upon those patients who have no third-party aid in paying their hospital bills.

This method of simply passing the entire cost of the family practice residency program minus any fees which could be recovered from the outpatient operation on to the hospital inpatients has the attraction of being very easy for the providers of care. However, it must be recognized that this alternative would shift payment for the education program and, to some extent, for health care services to a limited population which may be receiving little direct benefit from the program. A central consideration here must be the ethical question of having one

group of patients, most probably unknowingly, pay for the health care of another group of patients. All patients at Lutheran General Hospital would benefit from a graduate medical education program, at least indirectly, through the creation of a house staff. However, is this sufficient reason to levy an across-the-board flat assessement against every inpatient who uses the hospital?

It is also doubtful that third-party payers who are going increasingly to reimbursement by cost of care will long tolerate the payment of the outpatient portion of this program when they do not provide outpatient care under their own programs.

Funds under this alternative would be generated slowly on a per-day-per-patient basis as patient accounts are collected from the payment source. Thus, no large pool of funds would be available to offset expected large start-up costs.[13] In general, this source of funds would provide a guaranteed funding for the program as long as the charges could legally be passed on to all inpatients under existing third-party arrangements.

If Lutheran General Hospital had used this method in 1971 and if no outpatient funds had been recovered, then one could project the following per patient day cost of the proposed first-year program. With a program cost of $142,903 (see Appendix F) divided by the hospital's 1971 patient days of 53,092 (see Appendix G), one would arrive at a cost of

$2.69 per patient day. Thus, a patient who had a 10-day stay at Lutheran General Hospital during 1971 would have paid $26.90 towards the cost of the graduate medical education.

Advantages of Alternative One.--The advantages of this alternative are:

1. Funding of the first full residency cycle of the program would be guaranteed, but only insofar as the funds would be generated along the way as the program progressed.

2. Physicians would be satisfied with this source since they would have no responsibility for funding the program. The hospital would bear full financial responsibility for the program.

3. The hospital would be satisfied as long as it was free to raise its prices, since it would be continuously passing the cost of the family practice residency program on to all of the inpatients of the hospital.

Disadvantages of Alternative One.--Disadvantages of this solution are:

1. All inpatients or their third-party payers would be forced to pay the cost of the graduate medical education program whether or not they have received direct benefit from the program.

2. With the ever-increasing dependence of Lutheran General Hospital on Medicare and Medicaid (see Appendix E), funding would

be largely under the control of these outside programs. Minor changes in both or either one of these programs could leave the family practice residency program without a source of funds. This would force funding on the continuously decreasing number of private third-party and direct-pay patients (see Appendix E).

Alternative Two

Alternative Two is to obtain direct government funding to include local, state, and federal programs which may serve as sources of funding for the family practice residency program. The state of Texas has empowered local areas to establish hospital tax districts to provide such medical care to local patients as they may require it. This means that Lutheran General Hospital cannot obtain local or state governmental reimbursement for the treatment of local indigent patients.[14]

The Bexar County Hospital and the Robert B. Green facility provide a wide range of both inpatient and outpatient care to local San Antonio citizens. These facilities are supported by the Bexar County Hospital Tax District. Although Lutheran General Hospital is effectively cut off from direct state and local funds, it could obtain funds from several federal sources to finance the family practice residency program. Under the Comprehensive Health Manpower Training

Act of 1971 (Public Law 92-157), federal funds are available to "plan, develop, and operate or participate in a professional training program in the field of family medicine and to provide trainingships and fellowships to medical students, interns, residents, practicing physicians or other medical personnel who are participating in a family medicine training program."[15] A total of $5 million was available in Fiscal Year 1972. This program is under the Office of Special Programs of the Department of Health, Education, and Welfare.

Under another section of the Comprehensive Manpower Training Act of 1971 (Public Law 92-157), institutional grants are available annually, beginning in Fiscal Year 1972, to "assist in meeting the education costs of the first three years of approved graduate training programs in the area of primary care." This program would provide public or non-profit private hospitals $3,000 per year per student if the facility undertook to increase enrollment in these programs.[16] This program is not available for start-up funds, but it would offer future sources of funds directly related to an established operating family practice residency program such as Lutheran General Hospital will have at some future date.

Other federal programs, which at times may seem boundless, are not readily available to Lutheran General Hospital. The Office of Economic Opportunity (OEO) is a possible source of funding through

the Model Cities neighborhood in which Lutheran General Hospital is located. However, hospital contacts with the local Model Cities Agency have been sporadic, and no real bond exists between Lutheran General Hospital and the Model Cities Agency.[17] There appears to be no possibility of obtaining any funding in the near future for the family residency program from this particular federal source.

Advantages of Alternative Two.--Advantages of Alternative Two are:

1. Full funding for at least one full cycle of the residency program could be obtained by using federal grants. Funds would be on hand at the beginning of the program to offset expected high start-up costs.

2. The hospital would be satisfied with this source since federal funding would not increase or cause a financial problem for the hospital.

3. The physicians would be satisfied since federal funding would remove any possibility of financial responsibility from their participation in the program.

4. The patients would be satisfied since the cost of the program would be transferred to the tax-paying population of the United States. Patients would tend to forget that they, too, pay

taxes, but, in any case, their individual share for this program would be fairly minute.

Disadvantages of Alternative Two.--Disadvantages of this alternative are:

1. The hospital has had little experience in obtaining direct federal support and it may lack the expertise in obtaining the competitive federal grants which may be necessary in using this source.[18]

2. The Special Programs grants have been available since July 1, 1971, and may be exhausted by the time the hospital can apply.

3. Federal programs may carry requirements which place undue restrictions upon the hospital, such as the requirement to treat a special category of patient.[19]

Alternative Three

Alternative Three is to obtain funds for the family practice residency program by way of philanthropy on a local or a national level by the aggressive use of a development program. Philanthropy is not dead, as Smith and others have shown.[20] Lutheran General Hospital has a full-time development director who has been with the hospital for approximately four years. The development program has been of respectable size, with efforts being directed mainly toward building

funds and special equipment purchase programs.[21]

The family practice residency program is a relatively new program for which many people hold high hopes that it may solve a basic problem of the health care system. However, many programs, because of a lack of direct federal funding, at least until recently, and because of the acute health care in urban low-income areas, have come to the attention of large, prosperous foundations which have been interested in health care programs in general. Thus, the W. K. Kellogg Foundation of Battle Creek, Michigan, is presently funding a family practice residency program in a large Midwestern city. In a private interview, the vice president for programs of the Kellogg Foundation indicated that it would be interested in a program such as the one being developed at Lutheran General Hospital.[22]

Two other foundations contacted were divided in their willingness to fund this program. The Moody Foundation of Galveston, Texas was not interested in the program at all.[23] The Commonwealth Fund of New York was willing to consider an application for a grant from Lutheran General Hospital.[24] This information does not represent conclusive or statistical proof that national private foundation funding is going to be gained for the program but it does indicate that funding is possible under this alternative.

Lutheran General Hospital has had an active development program in the local San Antonio area, but the hospital has made little use of

national philanthropic foundations as of this time. The development program has been oriented to the local Lutheran community and other old friends of the hospital. Although many donations and gifts have been received, they have been relatively small.[25] Development has been on a local person-to-person basis, with little or no formal public relations effort except for major building fund drives.[26] However, the development and the public relations offices are full-time areas of the present hospital staff of Lutheran General Hospital and provide an excellent potential fund-raising tool. As the development director of Lutheran General Hospital has stated: "Contributions are proportioned to the size of your proposed program."[27] The development office offers an excellent means of raising funds for the family practice residency program, particularly if national foundations are used to obtain funds.

Advantages of Alternative Three.--Advantages of this method of funding are:

1. Funds obtained from a national foundation would guarantee funding for at least one complete residency cycle. Funds would be on hand before the training program was undertaken.

2. The hospital would be satisfied because outside funding would not increase any current financial problems. The hospital would also gain added prestige from a nationally funded program.

3. The physicians would be satisfied since this would not add to nor create any new financial responsibility for the physicians and it would free the program of any financial problems.

4. Patients would be satisfied since funding would be shifted to a national tax-exempt "charitable" foundation and patients would have the least possible burden for the funding of the program.

5. Lutheran General Hospital has a full-time development director, and obtaining these types of funds should be simply an additional program for his office.

Disadvantages of Alternative Three.--Disadvantages of this solution are:

1. The hospital development officer has had little experience in dealing with national foundations in seeking funds and, thus, may lack the expertise, or "grantsmanship," to obtain funds from these sources.

2. Funding from a national foundation could involve restrictions on the program that might make this source of funds unacceptable. Thus, for example, if a national foundation were to insist that a not-for-profit group practice be established to conduct the residency program, it is very doubtful that the medical staff would accept this source of funds.

Alternative Four

Alternative Four is to assess each member of the attending

staff a per patient charge to provide funds to finance the family practice residency program. This particular method of financing graduate medical education has been used in large teaching hospitals in which teaching staff members receive a teaching salary from the hospital and/or collect patient fees directly from patients or third-party payers.[28] This method assumes that the teaching chiefs or physicians involved in a medical education program have a separate means of livelihood which will provide the teacher a source of income other than the teaching program.

The medical staff of Lutheran General Hospital is composed of private practicing physicians who receive no pay from the hospital. The hospital has no intention of paying full-time service chiefs under the family practice residency program. A full-time medical director will be hired, but he will be a program coordinator and not a practicing physician.[29] The hospital pathologist and radiologist are both fee-for-service physicians who bill hospital patients separately for their service. It should be noted that, since Lutheran General Hospital will be paying a salary only to the medical director and the residents, all other physicians will have to obtain their remuneration from their regular practice or from a third-party payer willing to reimburse them at least for inpatient services rendered under the program.

The medical staff of the hospital is strongly in favor of

establishing the family practice residency program on a fee-for-service basis. The desire to use the fee-for-service approach is an integral part of the overall teaching program for the family practice resident.[30] The approach has been used in many existing programs in the group practice or the professional associate mode of delivery.[31] The fee-for-service aspect could also be used to recover at least some outpatient costs.

Advantages of Alternative Four.--Advantages of this alternative are:

1. Funding for a full residency would be guaranteed since all physicians using Lutheran General Hospital would be assessed a fee for the use of the hospital.

2. The hospital would be satisfied with this method since it would guarantee funding for the program.

3. The patients would be satisfied with the alternative since technically their physicians and not they would be paying the per patient charge.

Disadvantages of Alternative Four.--Disadvantages of this alternative are:

1. It is highly unlikely that the physicians on the medical staff of Lutheran General Hospital would accept this method of financing the program. With no hospital teaching salaries being paid to the involved

physicians, it is impossible to conceive of this alternative as being acceptable to the physicians of Lutheran General Hospital.[32] The physicians would most likely pass the assessment on to patients in the form of higher bills.

2. This system would require a drastic reordering of the current professional operating procedures of Lutheran General Hospital. Since at present the hospital has no house staff, all of the patients of the hospital are private patients with their own personal physicians; the assessment of these physicians would have to be done only at the risk of losing them as members of the staff. It is highly unlikely that the family practice residency program alone could generate sufficient inpatients to pay for its own costs. Assessment of all active staff members would be necessary, but it would not be acceptable to the medical staff of Lutheran General Hospital.

Alternative Five

Alternative Five is to use private financing to include all forms of debt financing to fund the family practice residency program at Lutheran General Hospital. This alternative represents an attractive and "modern" application of general business methods to the more reserved hospital financial field.

The sources of funds here are as varied as the places and the ways in existence to borrow money. A current article has discussed

the use of tax-exempt bonds secured by operating revenue, by liens against property, and by liens against gross revenue such as third-party payments due.[33] Francoeur has outlined considerations for using both short- and long-term commercial loans to finance hospital programs.[34] Hahn sees the role of the bank and the insurance company increasing as sources of financing of capital funds for hospitals.[35]

However, it must be recognized that borrowing is not without its problems. If the program funded cannot produce sufficient revenue to meet its expenses, then any form of borrowing for a tax-exempt nonprofit hospital is a highly dubious procedure. At present, Lutheran General Hospital has estimated that the family practice residency program, if operated on a fee-for-service basis, would recover 10 per cent of its cost the first year, 40 per cent the second year, and 70 per cent the third year; by the fourth year of operation, the program would be self-supporting.[36] There is some evidence in the current literature to make these estimates appear overly optimistic.[37]

Lutheran General Hospital currently has outstanding loans amounting to $1,370,000, and a 60-bed expansion program planned for 1972-73 will increase the total debt of the hospital to $4,100,000 by April, 1973. The hospital is very reluctant to borrow operating funds to finance a program for which no on-cite historical data are available

to demonstrate the financial reliability of the program.[38]

Advantages of Alternative Five.--Advantages of Alternative Five are:

1. Funds for a full residency program would be guaranteed by borrowing the total needed for the three years and holding the capital to offset the cost of the program. A greater amount would be on hand initially to offset high start-up costs.

2. The physicians would be satisfied with this source since the full financial burden would be shifted to the hospital.

Disadvantages of Alternative Five.--Disadvantages of Alternative Five are:

1. The hospital is very reluctant to borrow what it considers to be operating funds to fund a program which may or may not be self-supporting.[39]

2. The inpatients of Lutheran General Hospital would, in the end, be forced to bear the cost of the program. A loan would only spread the cost of the program over an extended period of time, and patient charges would have to be used to enable the hospital to pay off a loan. If the program became a consistent money loser, the inpatients of Lutheran General Hospital would have to bear the cost of the program.

Summary

This discussion has presented a great number of advantages

and disadvantages which would influence Lutheran General Hospital in selecting a best source of funding for the family practice residency program. At this point, it would be best to compare the various alternatives as to how each has or has not met criteria and limitations affecting the stated problem.

Guaranteed funding for one full residency cycle prior to the beginning of the program

All five alternatives could meet this limitation, but in varying degrees. Alternative Two, government funding, and Alternative Three, private national foundation funding, and Alternative Five, debt financing, would all completely satisfy the limitation. Money could be obtained from any of these sources to fund the complete residency program through the first three years, and, if funding at that level were not obtained, then the program could be postponed or cancelled. Alternative One, to increase inpatient charges, and Alternative Four, to assess the attending staff, could both in time generate enough money for one complete cycle if the hospital remained in operation and if the attending staff did not all resign. However, no real "money-in-the-hand" guarantee exists with these sources, and, if Alternative Four were restricted to assessing fees from physicians participating in the family practice residency program, there would be an excellent chance that the fee would not cover the cost of the program. Alternatives Two

Three and Five have a distinct advantage in this area.

Physician acceptability

Only Alternative Four can be clearly discounted here. The physicians of Lutheran General Hospital would not accept this alternative as a source of funding. Alternatives Two and Three would offer clear attractions to the physicians since the family practice residency program would be completely funded from outside sources. Alternative Three, using national foundations with a minimum of restriction, would be most acceptable to the physicians. Federal funding without excessive restrictions would be accepted, but an overly restricted federal program would not gain the support of the medical staff of Lutheran General Hospital.[40] Alternatives One and Five would be acceptable to physicians but, since in the case of Alternative One patient charges would be increased and in the case of Alternative Five charges would have to be increased at least to cover the debt financing, the physician could be expected more readily to accept a program which does not affect the status quo at all over one that will affect it even in a limited way. Alternatives Two and Three, in that order, at the sources of choice here.

Patient acceptability

The patients could be expected really to react only to Alternative One and possibly to Alternative Four. If the cost of medical

education were made a visible part of every patient's bill, Alternative One would become unacceptable quickly. Alternative Five would cause such a small initial increase in inpatient charges that the patient could hardly be expected to notice it. Alternatives Two and Three offer real benefit to patients, especially those who must pay their own bills since funding would come from the national level in both cases. Alternative Four, although it may apply to some patients, would surely end in increased physicians' bills to patients to cover the cost of the physicians' assessment. Alternative Four would be as unattractive to inpatients as it is to physicians on the medical staff of Lutheran General Hospital. Alternatives Two and Three would be alternatives of choice here, with Alternative Five as a distant third choice.

Hospital acceptability

Alternative One would be relatively undesirable from the hospital's viewpoint since inpatient charges would have to be increased as soon as the program was put into operation. As for Alternative Five, while holding attractiveness as a way in which the hospital has funded construction for a number of years, the hospital is very reluctant to borrow funds against a program of doubtful profitability. Alternative Four would cause a massive disruption of the medical staff and would cause the hospital no end of trouble. This alternative would be less attractive to

the hospital than it would be to the patients. Alternatives Two and Three offer the hospital the hope of operating the family practice residency program with little or no financial danger for the hospital. These would be the alternatives of choice for the hospital.

Findings

Alternative Two, federal funding, and Alternative Three, private national foundation funding, appear as equally attractive sources of funds to the hospital, the medical staff, and the patients of the hospital. They both can be expected to provide the guarantee of sufficient funds for one complete residency cycle. Alternative Four and Alternative Five would be acceptable to one or more of the key participants in the program. Alternative One seems less than proper in charging inpatients for the full cost of the program. However, as noted as part of Alternative Four, it would be only proper that a fee-for-service program, collecting a reasonable fee from those patients of the family practice residency program who can pay, should be a part of the family practice residency program.

Footnotes

[1]Henry J. Rockstroh, Administrator, Lutheran General Hospital, San Antonio, Texas, private interview, February 28, 1972.

[2]Dr. David A. Berchelman, Director of Medical Education, Lutheran General Hospital, San Antonio, Texas, private interview, February 29, 1972.

[3]Commission on Education, p. 132-B.

[4]William W. Klier, Assistant Administrator for General and Professional Services, Lutheran General Hospital, San Antonio, Texas, private interview, March 2, 1972.

[5]Commission on Education, p. 132-B.

[6]Harold T. Grabau, Development Director, Lutheran General Hospital, San Antonio, Texas, private interview, March 2, 1972, and April 13, 1972.

[7]Billy J. Carter, Assistant Administrator for Fiscal and Administrative Services, Lutheran General Hospital, San Antonio, Texas, private interview, February 29, 1972; April 10, 1972; and April 13, 1972.

[8]William W. Klier, Assistant Administrator for General and Professional Services, Lutheran General Hospital, San Antonio, Texas, private interview, March 2, 1972.

[9]Henry J. Rockstroh, Administrator, Lutheran General Hospital, San Antonio, Texas, private interview, February 28, 1972.

[10]Fein and Weber, p. 123.

[11]Reed, p. 182.

[12]Billy J. Carter, Assistant Administrator for Fiscal and Administrative Services, Lutheran General Hospital, San Antonio, Texas, private interview, February 29, 1972; April 10, 1972; and April 13, 1972.

[13]McNulty, p. 409.

[14]Billy J. Carter, Assistant Administrator for Fiscal and Administrative Services, Lutheran General Hospital, San Antonio, Texas, private interview, February 29, 1972; April 10, 1972; and April 13, 1972.

[15]Health Funds Institute, The Health Funds Directory I (Concord, Mass.: Haney Associates, Inc., 1972), vii.

[16]Ibid.

[17]Peg Barry, Director of Public Relations, Lutheran General Hospital, San Antonio, Texas, private interview, April 19, 1972.

[18]Billy J. Carter, Assistant Administrator for Fiscal and Administrative Services, Lutheran General Hospital, San Antonio, Texas, private interview, February 29, 1972; April 10, 1972; and April 13, 1972.

[19]U.S., Office of Economic Opportunity, The Comprehensive Neighborhood Health Services Program Guidelines, OEO Guidance No. 6128-1 (Washington, D.C.: Government Printing Office, November, 1969), p. 13.

[20]Smith, p. 96.

[21]Harold T. Grabau, Development Director, Lutheran General Hospital, San Antonio, Texas, private interview, March 2, 1972, and April 13, 1972.

[22]Andrew Patullo, Vice President for Programs, W. K. Kellogg Foundation, Battle Creek, Michigan, private interview conducted at United States Army Medical Field Service School, Fort Sam Houston, Texas, February 23, 1972.

[23]Harold T. Grabau, Development Director, Lutheran General Hospital, San Antonio, Texas, private interview, March 2, 1972, and April 13, 1972.

[24]Edward L. Protz, Private Communication with the writer of this Thesis, The Moody Foundation, Galveston, Texas, April 12, 1973. (Typewritten.)

[25]Reginald H. Fitz, Private Communication with the writer of this Thesis, The Commonwealth Fund, New York, March 20, 1973. (Typewritten.)

[26]Peg Barry, Director of Public Relations, Lutheran General Hospital, San Antonio, Texas, private interview, March 2, 1972, and April 13, 1972.

[27]Harold T. Grabau, Development Director, Lutheran General Hospital, San Antonio, Texas, private interview, March 2, 1972, and April 13, 1972.

[28]Harry T. Paxton, "How Medicare is Affecting Training," Hospital Physician, III (August, 1967), 41.

[29]Henry J. Rockstroh, Administrator, Lutheran General Hospital, San Antonio, Texas, private interview, February 28, 1972.

[30]Dr. Charles Thuess, Assistant Director of Medical Education, Lutheran General Hospital, San Antonio, Texas, private interview, February 28, 1972.

[31]Commission on Education, pp. 133-1-133-20.

[32]Dr. David A. Berchelman, Director of Medical Education, Lutheran General Hospital, San Antonio, Texas, private interview, February 29, 1972; and Dr. Charles Thuess, Assistant Director of Medical Education, Lutheran General Hospital, San Antonio, Texas, private interview, February 28, 1972.

[33]Reed, pp. 76-77.

[34]Robert L. Francouer, "Considerations for Commercial Loans," Hospitals, XLVI (March 1, 1972), 122.

[35]Hahn, p. 58.

[36]Billy J. Carter, Assistant Administrator for Fiscal and Administrative Services, Lutheran General Hospital, San Antonio, Texas, private interview, February 29, 1972; April 10, 1972; and April 13, 1972.

[37]Phillips and Holler, p. 825.

[38]Billy J. Carter, Assistant Administrator for Fiscal and Administrative Services, Lutheran General Hospital, San Antonio, Texas, private interview, February 29, 1972; April 10, 1972; and April 13, 1972.

[39]Ibid.

[40]Dr. David A. Berchelman, Director of Medical Education, Lutheran General Hospital, San Antonio, Texas, private interview, February 29, 1972.

CHAPTER III

CONCLUSION

Conclusions

Based upon data and information presented in this study, the writer has arrived at the following conclusions:

1. A multisource combination of alternatives Two and Three should be used at Lutheran General Hospital to guarantee funding for at least one residency cycle and to recover funds from every possible source. Lutheran General Hospital should, at the same time, seek funding from both federal programs and national private foundations willing to support the program.

2. The family practice residency program should be established as a fee-for-service operation so that maximum recovery of outpatient cost is possible and to provide the possibility for future economic viability of the program.

Recommendations

The following recommendations are made to Lutheran General Hospital:

1. The development office should begin to seek financial support for the family practice residency program from any national

Foundation which has possible interest in or history of funding this type of program or related health care programs. Inquiries should be made to the following national foundations as a minimum:

a) W. K. Kellogg Foundation
400 North Avenue
Battle Creek, Michigan 49016

b) The Commonwealth Fund
One East 75th Street
New York, New York 10021

2. An appropriate member of the staff should seek federal funding for the support of the family practice residency program under the Special Programs section of the Comprehensive Health Manpower Training Act of 1971 (Public Law 92-157). Inquiries should be forwarded to the Office of Special Programs, Bureau of Health Manpower Education, National Institute of Health, Public Health Service, Department of Health, Education, and Welfare, Washington, D. C.

3. A copy of this thesis should be forwarded to appropriate members of the medical staff, and, if possible, the organized form of the family practice residency program and the future responsibilities of hospital and medical staff as to operation and funding of the program should be determined. It should be possible to draw up a program of cost and revenue sharing before the family practice residency program is activated.

APPENDIX A

DEFINITIONS

DEFINITIONS

1. Christmas Seal Program.--This is a special fund-raising program conducted by the Lutheran General Hospital each year at Christmas time. The program is controlled by the American Lutheran Church, and only member churches of the Southern District of that organization can participate on a voluntary basis in the program. The program has no connection with any national fund-raising program. Proceeds of the program are used by Lutheran General Hospital to provide "charity" care to patients, who must be recommended by their attending physician for special consideration. This status must be approved by the administrator of the hospital before these funds can be used to pay for patient care.

2. Family physician.--A family physician is one who:

> 1) serves as the physician of first contact with the patient and provides a means of entry into the health system; 2) evaluates the patient's total health needs; provides personal medical care within one or more fields of medicine, and refers the patient when indicated to appropriate sources of care while preserving the continuity of his care; 3) develops a responsibility for the patient's comprehensive and continuous health care and when needed acts as a coordinator of the patient's health services; and 4) accepts responsibility for the patient's total health care, including the use of consultants, within context of his environment, including the community and the family or comparable social unit.[1]

The terms primary physician and "physician of first contact" are

also used in the medical literature to denote the family physician.

3. Family practice.--Family practice is that branch of medical practice which includes family medicine with those added skills of internal medicine, pediatrics, psychiatry, obstetrics and gynecology, and surgery necessary to function as a primary or first contact physician.

4. Family practice residency program.--This is a formal, normally nationally approved 3-year course of instruction in graduate medical education which includes those "essential" elements of curriculum required by the American Academy of General Practice, the American Medical Association, and the Advisory Board for Medical Specialties. The program combines the one year of internship with the two years of residency within a single 3-year residency program.

5. Graduate medical education.--This entails the internship and the residency years spent in a formal training program normally leading to a specialized practice. This does not include continuing medical education, and fellowships are not normally considered a part of this field.

6. Model Cities neighborhood.--This is a specific, geographically defined area in a city which, because of its location and its population, meets certain federal guidelines and thus is eligible for

special federal funds under the Model Cities Program. Lutheran General Hospital is located in the center of the Model Cities neighborhood of the city of San Antonio, Texas.

Footnotes

[1]Commission on Education, p. 132-B.

APPENDIX B

MODIFIED INCOME STATEMENT OF LUTHERAN GENERAL HOSPITAL

MODIFIED[a] INCOME STATEMENT

LUTHERAN GENERAL HOSPITAL

Statement of Income -- General Fund

	Years Ending June 30	
	1971	1970
Income from Services to Patients	$4,080,881	$3,622,474
Deductions	493,086	502,636
Net Patient Income	$3,587,795	$3,119,838
Other Operating Income	84,123	99,561
Total Operating Income	$3,671,918	$3,219,399
Operating Expenses	3,630,710	3,135,299
Operating Income	$ 41,208	$ 84,100
Nonoperating Income	16,089	12,131
Net Income	$ 57,297	$ 96,231

[a]This statement was modified from the original statement at the request of hospital authorities and with their approval.

APPENDIX C

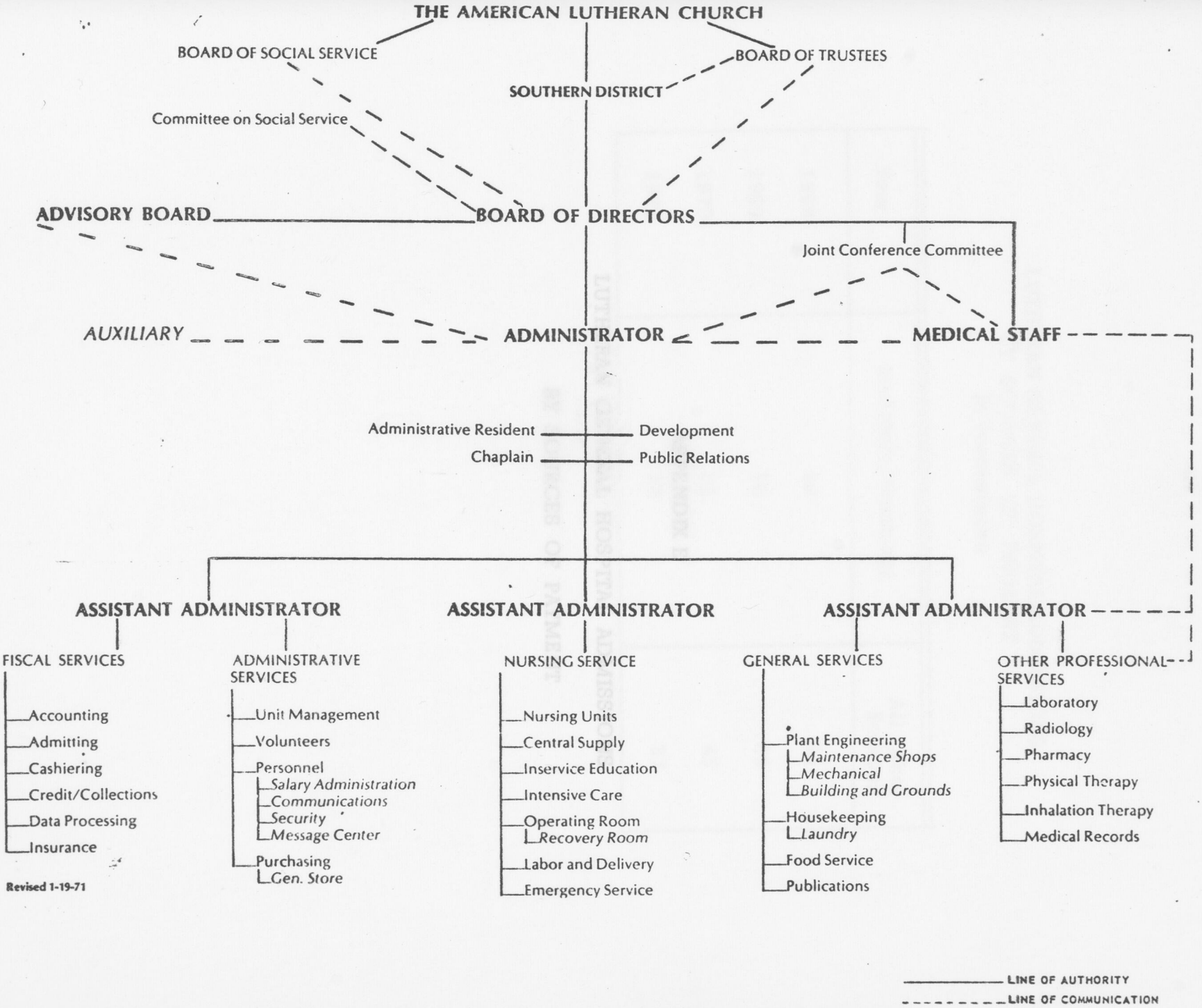
PHILANTHROPY FROM ALL SOURCES DONATED TO LUTHERAN GENERAL HOSPITAL FOR THE YEARS 1969-1971

PHILANTHROPY FROM ALL SOURCES DONATED TO
LUTHERAN GENERAL HOSPITAL
Totals are as of December 31 for the
Years Indicated

Year	Total Contribution
1969	$161,597.32
1970	119,675.77
1971	171,673.58

APPENDIX D

ORGANIZATIONAL CHART SHOWING THE CHAIN OF COMMAND FROM THE AMERICAN LUTHERAN CHURCH TO LUTHERAN GENERAL HOSPITAL


THE AMERICAN LUTHERAN CHURCH
BOARD OF SOCIAL SERVICE
BOARD OF TRUSTEES
SOUTHERN DISTRICT
Committee on Social Service
ADVISORY BOARD
BOARD OF DIRECTORS
Joint Conference Committee
AUXILIARY
ADMINISTRATOR
MEDICAL STAFF
Administrative Resident
Development
Chaplain
Public Relations
ASSISTANT ADMINISTRATOR
ASSISTANT ADMINISTRATOR
ASSISTANT ADMINISTRATOR
FISCAL SERVICES
Accounting
Admitting
Cashiering
Credit/Collections
Data Processing
Insurance
ADMINISTRATIVE SERVICES
Unit Management
Volunteers
Personnel
Salary Administration
Communications
Security
Message Center
Purchasing
Gen. Store
NURSING SERVICE
Nursing Units
Central Supply
Inservice Education
Intensive Care
Operating Room
Recovery Room
Labor and Delivery
Emergency Service
GENERAL SERVICES
Plant Engineering
Maintenance Shops
Mechanical
Building and Grounds
Housekeeping
Laundry
Food Service
Publications
OTHER PROFESSIONAL SERVICES
Laboratory
Radiology
Pharmacy
Physical Therapy
Inhalation Therapy
Medical Records
Revised 1-19-71
LINE OF AUTHORITY
LINE OF COMMUNICATION

APPENDIX E

LUTHERAN GENERAL HOSPITAL ADMISSIONS

BY SOURCES OF PAYMENT

LUTHERAN GENERAL HOSPITAL ADMISSIONS
BY SOURCES OF PAYMENT
In Percentages

Year	Medicare/Medicaid	All Other Sources
1968	47	53
1969	50	50
1970	55	45
1971	63	37

APPENDIX F

FAMILY PRACTICE RESIDENCY PROGRAM

PROPOSED BUDGET

FAMILY PRACTICE RESIDENCY PROGRAM

PROPOSED BUDGET

EXPENSES	1st Year	2nd Year	3rd Year
Direct Cost			
Medical Director	$ 30,000	$ 33,000	$ 36,300
Residents	24,000	24,000	24,000
Licensed Personnel	23,400	25,740	28,314
Other Personnel	21,000	23,100	25,410
Employee Health & Welfare	6,000	6,453	6,952
Medical and Office Supplies	7,500	7,500	7,500
Housekeeping	1,390	1,473	1,561
Plant Maintenance	1,710	1,813	1,922
Total Direct Cost	$115,000	$123,079	$131,959
Other Cost			
Administrative and General	$ 24,277	$ 25,958	$ 27,806
Nursing Service Administration	1,959	2,155	2,370
Total	$ 26,236	$ 28,113	$ 30,176
Depreciation	$ 1,667	$ 1,667	$ 1,667
Total Other Cost	$ 27,903	$ 29,780	$ 31,843
Total Cost of the Program	$142,903	$152,859	$163,802

APPENDIX G

LUTHERAN GENERAL HOSPITAL ADMISSIONS AND PATIENT DAYS FOR SELECTED YEARS

LUTHERAN GENERAL HOSPITAL ADMISSIONS AND PATIENT DAYS FOR SELECTED YEARS

Year	Admissions	Patient Days
1970	6,466	54,069
1971	6,890	53,092
To March 31, 1972	5,438	39,874

NOTE: All data are for fiscal years ending June 30 of year indicated. Admissions and patient days exclude newborns.

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ABSTRACT

A STUDY TO DETERMINE THE BEST SOURCES OF FUNDING FOR A FAMILY PRACTICE RESIDENCY PROGRAM AT LUTHERAN GENERAL HOSPITAL, SAN ANTONIO, TEXAS

A Problem Solving Thesis Submitted to the Faculty of Baylor University in Partial Fulfillment of the Requirements for the Degree of Master of Hospital Administration

by
Major James R. Burney, MSC

August 1973 75 Pages

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This study was designed to determine the best sources of funding for a family practice residency program at Lutheran General Hospital, San Antonio, Texas.

A review of current medical literature and numerous personal interviews were conducted in the problem area. The advantages and the disadvantages of various sources of funding the program were compared and evaluated.

The study determined that a multisource combination of federal government grants and national private foundation grants should be used to finance the family practice residency program. It was also concluded that the family practice residency program should be operated as a fee-for-service procedure.

Recommendations were made as follows: (1) to apply for funds from specific federal government offices and from national foundations; and (2) to formulate a cost and revenue-sharing plan between the hospital and the medical staff before the family practice residency program is activated.