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The Hospitals of Montana

Existing Facilities and Attendant Problems

BY
CARL F. KRAENZEL
DEPARTMENT OF AGRICULTURAL ECONOMICS
AND RURAL SOCIOLOGY

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FOREWORD

This information on the current hospital situation in Montana is released as a research report describing existing facilities and attendant problems. It will be followed later by a proposed plan for hospital location, distribution, and coordination to be prepared by the Committee on Hospital Surveys appointed by Governor Sam C. Ford in May, 1945.

It is hoped that this information will be used by Montana people in studying and planning their local needs. It appears that much hospital construction is now being proposed without first being considered in its relation to the larger problems of hospital organization and administration.

The supervision of this study, the collection of the data, the analysis of the information, and the writing of this report were largely the responsibility of Carl F. Kraenzel, Associate Professor of the Department of Agricultural Economics and Rural Sociology, Montana Agricultural Experiment Station. Miss Anna T. Beckwith, Secretary of the State Board of Examiners for Nurses assisted with the collection of data. She war formerly Superintendent of St. Peters Hospital in Helena. Much of the tabulation of data was done by Miss Anna Zellick, Research Assistant employed jointly by the State Board of Health and the Agricultural Experiment Station.

The study was carried on under the general supervision of a steering committee composed of members of the Montana Hospital Survey Committee. These steering committee members included Edwin Grafton, Superintendent of Shodair Crippled Children's Home and Chairman of the Montana Hospital Survey Committee; Milo Dean, Superintendent of Montana Deaconess Hospital, Great Falls; Sister Cornelia, Superintendent of St. John's Hospital, Helena; Father Frank C. Harrington of Butte; Dr. B. K. Kilbourne, Executive Officer, Montana State Board of Health; Dr. Edythe Hershey, formerly of the Maternal and Child Health Division, Montana State Board of Health; Miss Anna Pearl Sherrick, Head of School of Nursing, Montana State College; and Carl F. Kraenzel, Department of Agricultural Economics and Rural Sociology, Montana State College.

The cost of the survey and study was borne jointly by the Montana Agricultural Experiment Station and the Montana State Board of Health. The United States Public Health Service, through its Regional office at Denver, Colorado, made available the consulting services of Major L. B. Byington, Senior Surgeon and of Major Herbert T. Wagner, Surgeon.

Most members of the Montana Hospital Survey Committee have also made some form of contribution to the study. They will have the added future responsibility of suggesting a general hospital organization plan for the State as a guide to an improved hospital care program for Montanans.

Clyde McKee, Director
Montana Agricultural Experiment Station

Edwin Grafton, Chairman
Montana Hospital Survey Committee

THE HOSPITALS OF MONTANA

BY

CARL F. KRAENZEL
RURAL SOCIOLOGIST
AGRICULTURAL EXPERIMENT STATION
MONTANA STATE COLLEGE

INTRODUCTION

The decade of the Thirties did not bring many additions to the health and hospital facilities of Montana. Later, during the war, building restrictions and the pressure to get workers into essential civilian occupations and war work industries made necessary the postponement of basic hospital and health facility construction. War experiences made people more conscious of health and hospital needs and often forced the greater use of hospitals. In addition, shifts in population during the war period brought further pressure on the existing hospital facilities in some areas. Some parts of Montana had an increase in population. Other areas, already sparsely populated, and therefore having difficulty in supporting existing hospital and health facilities or having none at all, were faced with added difficulties and burdens because of population loss. Finally, as a result of favorable crop years and prices during the war, most political units in the State and most of the people were in a better financial position than ever before to support an expanded hospital and health care program.

For these and other reasons many communities in Montana have been making specific plans for additional or new hospital facilities. Frequent notices of such proposed plans for hospital or health center construction have appeared in the daily papers.

Before a well balanced hospital and health center program can be developed for Montana, it is important that the citizens look beyond the boundaries of their own communities to see what facilities are available in their less immediate vicinity and in the State as a whole. Perhaps a certain area already has too many hospital facilities or its existing facilities may be in the wrong locations. Perhaps proposed additions would only intensify an already unbalanced situation. Some knowledge of existing facilities will, without doubt, result in better plans for the future.

It was in this connection that Governor Sam C. Ford appointed a Hospital Survey Committee. Its members, some forty in number, represent most of the State-wide farm, labor, business, hospital, and service organizations of Montana. This survey was started in

July, 1945, and completed the following December. Since then the data have been analyzed, and this report is based on some of the information obtained. Additional information will become available in the near future. A short Extension Service bulletin discussing the relation among health centers, rural hospitals, and district hospitals is already available.[1] The Montana State Board of Health has recently published a bulletin on a proposed expansion of public health services in Montana.[2]

The Montana Hospital Survey Committee will take the information published here, plus additional data, and develop a general plan for suggested hospital location and distribution in Montana, to bring about a more effectively integrated hospital service program for the people of the State. This is also to be done in anticipation of the effect of Federal legislation pertaining to Federal assistance for hospital construction and a proposed plan for coordinated hospital service on an area basis. This Federal legislation,[3] when finally administered, probably will require cooperation of the states and communities under the following conditions:

(1) Federal financial assistance for hospital construction to a state is likely to be in the nature of a total grant, the amount varying in accordance with a long time average per capita income for the population of the state concerned and in accordance with other measures of need. There must be non-Federal money to match the grant.

(2) The amount of Federal money made available as a grant to the various states, no matter how liberal, will not be sufficient to cover much of the need, especially in Montana, nor will it be available at one time, but will be extended over a number of years.

(3) It will therefore be necessary to have a state agency to accept the Federal grant and distribute the funds within the state in accordance with certain established rules and requirements.

(4) To do this, it will be necessary to study the existing hospital facilities of the state and to develop some basic plan for coordinated hospital services by areas within the

[1]See "Planning Health Facilities for Montana People", Montana Extension Service Circular No. 166, March 1946. This was prepared cooperatively between the Montana Extension Service and the Steering Committee of the Montana Hospital Survey Committee.

[2]Kilbourne, B. K. "Public Health Services in Montana—Organization and Functions of County or District Health Units".

[3]Senate Bill 191 (Hill-Burton) which has the sanction of the three leading hospital associations of the Nation and various other agencies, including the medical profession, has passed the Senate and the House and was formally signed by President Truman in August of 1946.

state. This plan will be a guide for the distribution of the available grant money for construction of hospital facilities. The Federal legislation requires the establishment of such a master plan for the proposed location and distribution of hospital facilities.[4]

For convenience, and in order to show the location and distribution of hospital services for Montana, the entire area of the State was divided into thirteen districts (see figure 1). The boundaries are only tentative. Information on trade areas, natural barriers, type-of-farming areas, existing and prospective roads, highways, and potential health and hospital organization units were taken into consideration when establishing these areas for the State. Perhaps additional information will indicate a need for revising some of the boundaries.

Figure 2 shows the location of the general hospitals in Montana.

SIZE OF AREA, POPULATION DENSITY, AND BED CAPACITY

Table A gives some information on size, population density, number of hospitals, and beds by areas in Montana. The density of population for the entire State was 3.8 persons per square mile in 1940. One area had a density as high as 7.2 persons while another had as few as 1.5 persons per square mile. Some areas were much larger than others.[5]

There was a total of sixty-five general hospitals in the State as of August, 1945.[6] There are four special hospitals. Two are in area X. They are the Fort Harrison Veterans' Hospital and the Shodair Crippled Childrens' Hospital, both at Helena. Two are in area XII. They are the State Mental Hospital at Warm Springs and the State Tuberculosis Sanitarium at Galen.

Columns five and seven give the number of general and special hospital beds in Montana and for the different areas. Normal bed capacity represents that situation which allows for the minimum standard number of square feet of space per bed, usually

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[4]It is hoped that the material collected for this survey, and the final report to be prepared by the Montana Hospital Survey Committee will be used as the basis for such a plan. This Committee has not met for its final sessions, because the administrative interpretation of the legislation which has been passed will govern the final procedure. Such administrative rulings are now being written.

[5]The number of the areas in table A, and succeeding tables, correspond to the number of the areas in figure 1.

[6]A general hospital is an all-purpose hospital with no emphasis upon specialization in services. Special hospitals are those rendering special services only, such as tuberculosis hospitals, crippled childrens' hospitals, veterans' hospitals, and mental asylums.

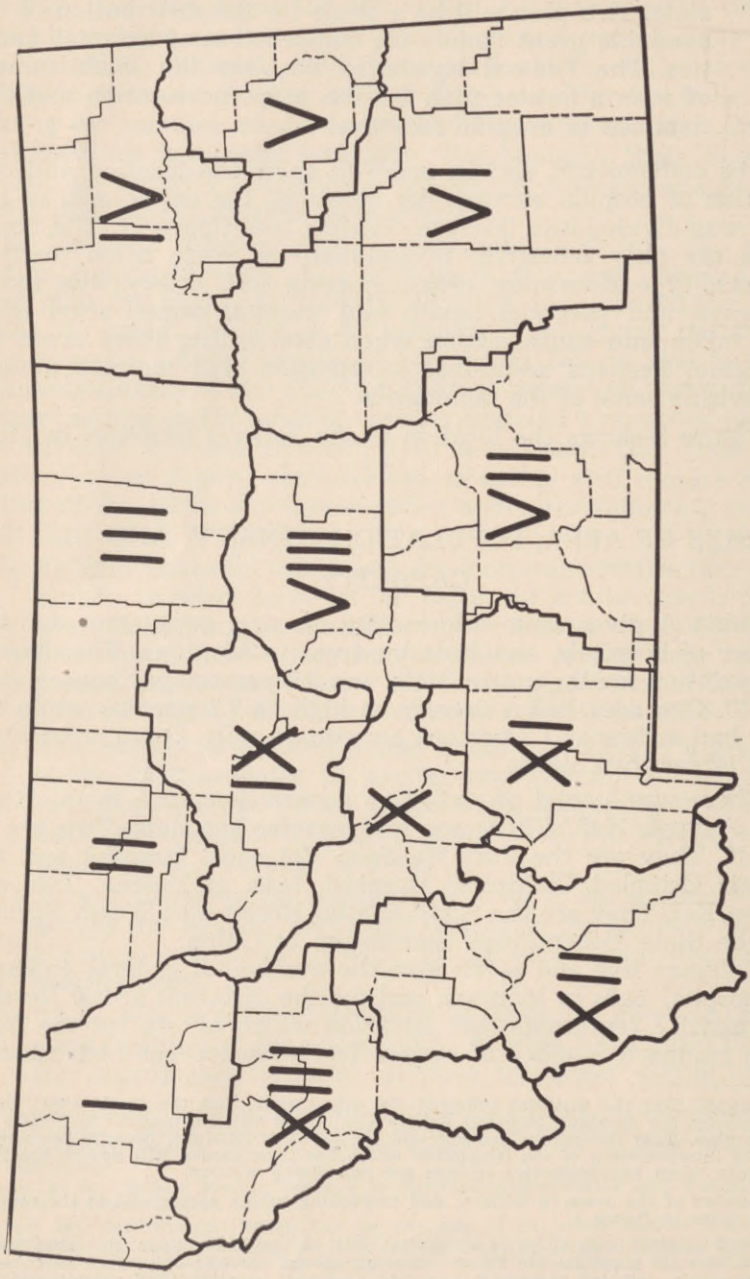

Figure 1. PRELIMINARY HOSPITAL AREAS FOR MONTANA

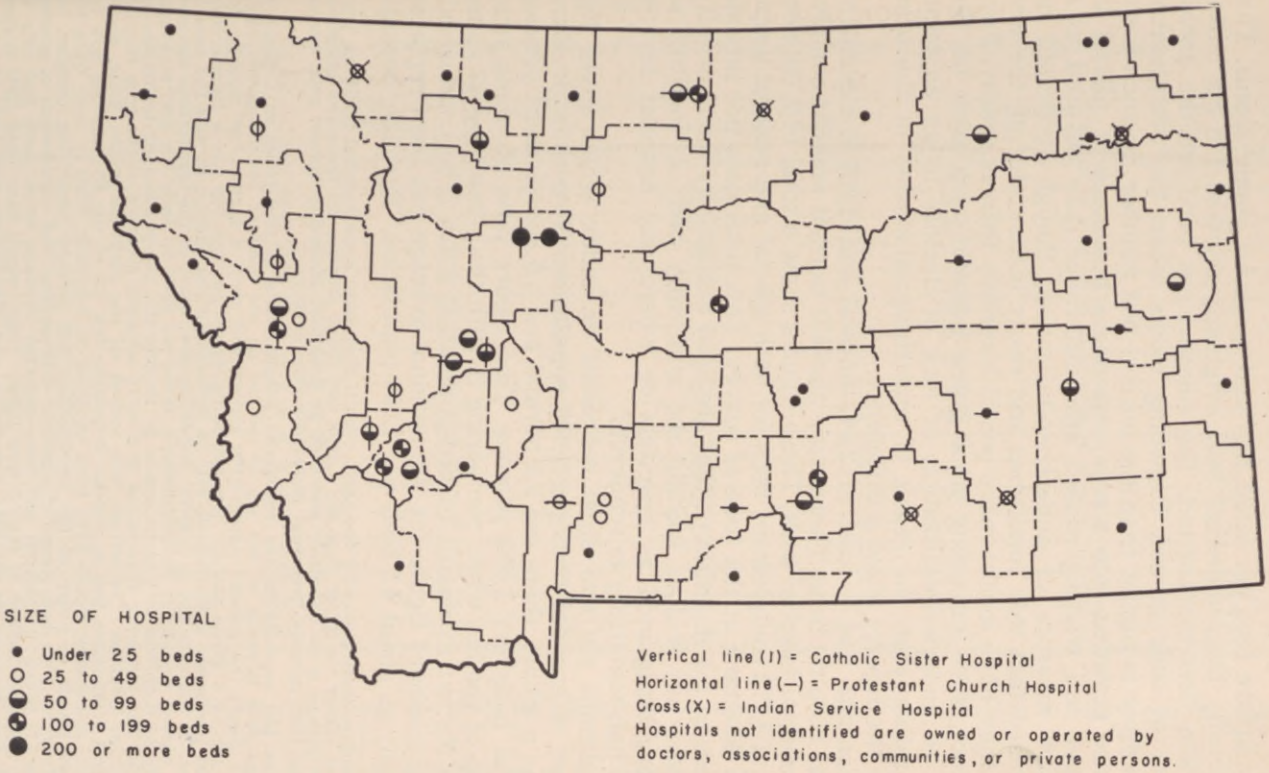

Figure 2. LOCATION AND SIZE (NORMAL BED CAPACITY) CLASSIFICATION OF GENERAL HOSPITALS IN MONTANA AS OF JANUARY 1946

eighty square feet per ward bed and more for single rooms. This is generally the number of beds originally allowed for the building when first constructed. The complement beds are the actual number of beds in use. Crowding exists when the complement bed number is higher than the normal bed number. In such cases beds are crowded into wards and single bedrooms or placed in hallways and waiting rooms. This difference may be used as a tentative measure of underhospitalization, though it should be recognized that war conditions and ready income during the war years may have meant more use of hospitals than normally. Furthermore, such crowding in a given hospital area may be the result of underhospitalization or lack of doctors in an adjacent area, rather than the result of underhospitaliziation in the area where the figures show a difference.

Montana had a total of 2,947 normal and 3,308 complement general hospital beds. There were also 821 normal and 864 complement special hospital beds. These figures show a total of 3,768 normal and 4,172 complement beds for both special and general hospitals in Montana at the time of survey. This total does not include the beds in the institutions that are used exclusively for maternity purposes, but it does include the maternity beds in institutions that are designated as hospitals or where any hospital service other than maternity is rendered.[7]

Columns six and eight represent an index which gives the number of hospital beds per 1,000 population. Note that for Montana as a whole, there are 5.3 normal and 5.9 complement general hospital beds per 1,000 persons. This figure puts Montana near the top of the list when comparing it with the remaining 47 states of the Nation in regard to bed-population ratio. The corresponding complement figure for the national average has been reported variously as about 4.5 beds per 1,000 population.[8] Perhaps, because

[7]For example, institutions for the aged, even if they have some hospital facilities, were excluded except for Silver Bow and Lewis and Clark counties. In these two instances, the institutions were definitely classified as hospitals. Maternity homes, used exclusively for that purpose, were not included in the survey.

[8]Even the bed capacity in the registered hospital lists of the American College of Surgeons puts Montana at the top of the list on the basis of bed-population ratio. Without doubt the present nation-wide survey will show a higher bed capacity for the Nation as a whole and for the remaining 47 states than the above figure, since hospitals previously not reported will be included in the survey, as was the case in Montana. If Montana had a hospital inspection law, some of the institutions included in this survey would not be in existence. Since we have no such law and standards to apply to hospitals, it was necessary to include the below standard insitutions as hospitals. The following illustration is a more accurate measure of the true hospital situation in Montana. The writer, who visited all the hospitals in the State, would guess that if Montana had a hospital inspection law, 22 of the 65 hospitals now included in the survey would have been excluded as hospitals. This is clear from the fact that people in many of the communities had already made that decision for themselves, for they had plans for complete abandonment and replacement of present facilities If these 22 hospitals had been excluded Montana would have had only 43 general hospitals instead of the 65 now listed. There would have been 2509 normal hospital beds in place of the 2947 now listed, and 2795 complement beds instead of 3308. This would mean a bed population ratio of 4.5 instead of 5.3 for normal beds, and 5.0 instead of 5.9 for complement beds.

TABLE A

AREA, POPULATION, DENSITY, NUMBER OF HOSPITALS, AND BEDS BY AREAS OF MONTANA

Areas	(1) Area (Square Mile)	(2) 1940 Population Total	(3) Density[a]	(4) Number of Hospitals[b]	(5) Normal Hospital Beds[c] Number	(6) Index[d]	(7) Complement Hospital Beds[e] Number	(8) Index[d]	(9) % Excess of Complement over Normal
I	9,992	40,113	4.0	5	93	2.3	104	2.6	11.8
II	9,417	26,364	2.8	5	141	5.3	151	5.7	7.1
III	13,455	32,701	2.4	4	227	6.9	235	7.2	3.5
IV	12,372	39,666	3.2	6	130	3.3	146	3.7	12.3
V	7,052	20,937	3.0	3	87	4.2	97	4.6	11.5
VI	23,176	34,292	1.5	7	156	4.6	234	6.8	50.0
VII	15,091	77,214	5.1	8	334	4.3	433	5.6	29.6
VIII	8,467	21,162	2.5	1	119	5.6	119	5.6	
IX	8,428	54,857	6.5	4	487	8.9	506	9.2	3.9
X	6,270	28,384	4.5	4	249	8.8	249	8.8	
XI	9,495	36,839	3.9	4	112	3.0	144	3.9	28.6
XII	12,532	89,674	7.2	7	488	5.4	535	6.0	9.6
XIII	10,569	57,275	5.4	7	324	5.7	355	6.2	9.6
State-General[f]	146,316	559,478	3.8	65	2,947	5.3	3,308	5.9	12.3
Special-Area X	146,316	559,478	3.8	2	193	0.4	193	0.4	
Special-Area XII	146,316	559,478	3.8	2	628	1.2	671	1.2	6.8
State-Special[g]	146,316	559,478	3.8	4	821	1.5	864	1.5	5.2
State-Total	146,316	559,478	3.8	69	3,768	6.7	4,172	7.5	10.7

[a]Persons per square mile.

[b]As of August, 1945.

[c]Normal beds, i. e., standard bed capacity for which the hospital was constructed, giving space at about 80 square feet per ward bed and more for single bed rooms.

[d]Number of beds per 1,000 population.

[e]Complement beds, i. e., the present number of beds set up for in-patient care.

[f]General beds, i. e., general hospital means care in a hospital other than a special hospital.

[g]Special Hospitals include Warm Springs for the mentally ill, Galen for the tuberculous, Fort Harrison for veterans, and Shodair for crippled children.

of sparsity of population, Montanans need more beds, and perhaps they use hospitals more than people in other parts of the Nation. That the number of beds per 1,000 population increases as the density of population decreases is a known fact. There are logical explanations why this should be true.

A study of the bed-population index for the various areas of the State shows considerable variation. Two areas (I and XI) have three or fewer normal beds per 1,000 population based on the 1940 census of population. Such a low bed-population ratio represents underhospitalization, especially since the complement beds, indicating crowding, exceed the normal beds by 11.8 percent in area I and by 28.6 percent in area XI. However, there are other areas with a higher difference between normal and complement beds, and a higher bed-population ratio than in areas I and XI. Hence there is either a lower use of hospital facilities in these latter areas, or more of those using hospital beds go outside the areas for hospitalization, or both. Six areas (I, IV, V, VI, VII and XI) have a bed-population ratio lower than the State average for normal beds. These areas also have the greatest percentage of excess of complement beds over normal beds. While this excess of complement beds over normal beds is 12.3 percent for all general hospitals for Montana as a whole, three of these areas have a similar percentage (11.5, 11.8, and 12.3) and three have a considerably higher percentage, namely 28.6, 29.6, and 50.0.

Two areas (IX and X) have more than eight normal hospital beds per 1,000 population. In one, the complement beds exceed the normal beds by 3.9 percent; in the other there is no difference. These areas may have too many hospital beds, especially in the future, when some of the smaller communities in these areas and some of the communities in adjacent areas will have added beds to the number they have at present. An excess of complement over normal beds in these instances may be due to underhospitalization in adjacent areas. Six areas have a higher bed-population index than the State average. Approximately the same situation prevails with reference to complement beds. In these six areas complement beds do not exceed the normal beds by an excessive amount. In fact, in two areas the complement beds do not exceed the normal beds, and in the other four areas the complement beds exceed the normal by 9.6 percent or less.

These facts disclose that some areas of Montana, in comparison with other areas, have too few hospital beds. Similarly, when the several communities within many of the areas are compared, a lack of balance in hospital facilities is manifest. The higher number of beds in some of the areas can be explained, in large measure, by the fact that the hospitals are strong enough to draw patients from an area larger than that indicated.

The concentration of hospital beds and the strong drawing power of some hospital centers have both desirable and undesirable features. The desirable aspect is that the larger hospitals are generally better equipped and better staffed with specialists than some of the smaller hospitals. Therefore, many people from the rural and small-town parts of Montana avail themselves of these advantages in the larger hospitals. On the other hand, the undesirable feature arises when the concentration of hospital beds in urban areas makes more difficult the survival of smaller hospitals in the less urbanized centers and in locations nearer to the farm and small-town people. This excessive centralization of hospital beds in the urban centers is also a factor in the pronounced urban concentration of doctors and their exodus from small-town and rural areas.

The issue of concentration versus decentralization in hospital facilities and medical personnel brings the medical and hospital care problem for rural people into sharp focus. The main problem is this: Should hospitals be larger and at some distance from many of the rural Montana people or should hospitals be smaller and closer to the rural people? Hospitals are the "workshops" of medical practitioners and, under the traditional system of fees for medical care, doctors are able to derive more income from surgery than from other medical services. Thus doctors tend to go where hospitals are located.

A parallel issue is then whether or not medical practitioners should be closer to many rural people. If national policy and social goals require that hospital facilities and medical personnel be kept closer to the rural population it becomes apparent that changes in traditional hospital and medical organization are in prospect.

In discussing the data in table A with people throughout the State, several objections were raised. These can be classified under four main headings and should be briefly explained. The objections were as follows:

(1) The small hospitals, especially those with less than 25 beds, should not have been included in the survey because they should not be classified as hospitals. This objection generally came from medical people.

(2) Some of the hospitals, noticeably the Northern Pacific Benefit Association Hospitals at Glendive and Missoula, serve population outside the State. Therefore, some of the bed capacity in these hospitals, though located in Montana, should be excluded from the count for Montana.

(3) Some hospitals, such as the Lewis and Clark County Hospital at Helena and the Silver Bow County Hospital at Butte, should have been excluded from the survey, since they are rendering service chiefly to aged people.

(4) The area lines are not in the proper place, but should be shifted in one way or another.

A short explanation of each point is in order. An answer to the first point—that many of the smaller hospitals enumerated in the survey should not have been classified as hospitals—is as follows: Montana has no hospital inspection law.[9] Consequently there was no standard to apply to determine whether a hospital should be called such or not. The only criterion that could be applied was whether or not people in the community concerned called the institution a hospital. If the local people thought of it as a hospital, called it a hospital, and if surgery and hospital work other than exclusively maternity care were rendered there, the institution was classified as a hospital for the purpose of this survey. Furthermore, legally licensed medical doctors practiced at all of the 65 hospitals included in the survey, and therefore, these small institutions had to be defined as hospitals. This fact again raises the issue of whether or not there should be small hospitals, especially for rural people.

The second objection, namely, that some of the hospitals, especially those mentioned in objection two, also serve an area outside of the State, and that therefore some of the bed capacity should be excluded, is a justifiable one. However, the situation cannot be dealt with easily or simply. Just as some of the present bed capacity in Montana serves population outside of the State, so it is true also that bed capacity outside of Montana serves population within the State. Williston, North Dakota, for example, serves some of the Glendive and Wolf Point territory, and the extreme western part of Montana is served by Idaho and Washington hospitals. In addition, many people from Montana go to certain special hospital centers outside of the State for medical care.

However, some special allowance should be made for the two Northern Pacific Association Hospitals,[10] one at Missoula and one at Glendive. The Missoula Northern Pacific Hospital has a total of 76 normal beds. Twenty-five of these are definitely set

[9]Montana has only an inspection law for maternity homes and maternity service in regular hospitals. This inspection is performed by the Maternal and Child Health Division of the State Board of Health, but does not apply to the remainder of the hospital service. The only means of maintaining hospital standards for Montana hospitals is through accreditation by the American College of Surgeons or through one of the several national hospital associations. However, this accreditation is based on only an occasional and sporadic review of the hospital asking for an inspection. Nonapproval by these organizations does not mean closing the hospital or improving existing services.

[10]These two hospitals are jointly owned and operated by the Northern Pacific Railroad Company and its employees in the name of the Northern Pacific Benefit Hospital Association. This association is one of the oldest prepaid medical care and hospitalization programs in the Nation. There are two additional hospitals in this organization—one in Tacoma, Washington, and one in St. Paul, Minnesota.

aside for use by private patients belonging to railroad families in Missoula and vicinity. Additional beds in the hospital are used by railroad employees living in Missoula and in the area served by Missoula hospitals, namely, area XIII. It is perhaps correct to say that 30 of the 76 normal beds in the Missoula Northern Pacific Hospital are used by railroad personnel from outside Montana. This would reduce the present total normal bed count for the Missoula vicinity to 189 beds and for area XIII to 294 normal beds in place of the 324 normal beds given in table A. The normal bed-population ratio would be 5.1 instead of 5.7, and the State ratio also would be lowered slightly.

The only large hospital at present in the entire Glendive vicinity is the Northern Pacific Hospital. It has a total of 57 normal beds. However, this hospital also serves the railroad workers from Laurel, Montana, to Jamestown, North Dakota, inclusive. A deduction of 11 beds to allow for the patients from outside the larger Glendive drawing area would reduce the normal bed facilities in the Glendive area to 46 and for the entire area to 66. This would mean a normal bed-population ratio of 3.6 rather than the 4.1 shown in table A.

This deduction of a total of 41 normal beds because of the adjustments in Missoula and Glendive would lower the normal bed-population index for the State as a whole from 5.3 to 5.2. Area V would more clearly fall into the underhospitalized areas of Montana, along with areas I, IV, and XI. The situation at Missoula and in area XIII would not change materially, especially when it is realized that about 18 additional beds are now available at St. Patrick's Hospital, over and beyond the 101 normal beds reported at the time of the survey. The reason for the availability of these 18 beds is that the completion of the new nurses' home at St. Patrick's Hospital has made it possible to move the Sisters out of the hospital into the nurses' home. Thus the 30 bed reduction for Missoula is actually only a 12 bed reduction, and the final normal bed-population ratio will be nearer 5.7 than 5.1.

With reference to the third objection, namely, that the Lewis and Clark County Hospital and the Silver Bow County Hospital should have been excluded as hospitals since they care largely or exclusively for aged, the answer is as follows: The Lewis and Clark County Hospital, with space for 100 patients but listed in this survey as having 78 normal beds, is of recent (1937-1938) construction and is a well-planned building. It was purposely built as a hospital. Most other institutions of this character were not constructed for hospital use but as detention homes or as homes for aged or else were converted from some other use. Since the survey was intended to be a description of existing and potential hospital capacity, it was necessary to include the Lewis and Clark County

Hospital, which was constructed as a modern hospital building. If the Lewis and Clark County Hospital were excluded as a hospital, there would be only 171 in place of the present count of 249 normal hospital beds in area X. However, this would still be a bed-population ratio of 6.0 compared with a ratio of 8.8 as at present (table A) or 5.3 for the State as a whole. In fact, by deducting the 78 beds the State ratio also would be decreased.

The Silver Bow County Hospital, though also used for the housing of aged people, is distinctly a hospital. The city of Butte and Silver Bow County, highly specialized mining areas, have many aged and public welfare cases which need hospitalization. The Murray Hospital, a private corporation, is not interested in performing charity functions. St. James does perform charity functions, but perhaps fewer than most other Catholic hospitals. Neither of these hospitals, located in a high priced urban area, can afford to take on a large number of charity cases or cases on which the county tends to pay a minimum. Hence the Silver Bow County Hospital has a specific hospitalization function to render.

Concerning the fourth objection, namely whether or not the lines between areas are in the right place, the following is an explanation. The purpose of dividing Montana into areas was to describe the existing situation in more detail than would have been possible had the information been given for the State as a whole. The boundary lines are not final and should be thought of as bands or areas of intersection with people going both ways, rather than sharp division lines with all people on one side going one way and those on the other going the other way. It should be recalled that if the boundary lines are changed for any one area, to include more or less population, the chances are also reasonable that existing hospital facilities must be shifted. For example, Polson is in the area from which people go either to Kalispell or to Missoula, or both, if and when they go to a city larger than Polson. If the line between areas I and XIII is shifted to include more of the Lake County population in area XIII, then it will also be necessary to include all or most of the hospital beds in Polson in area XIII. Thus the bed-population ratios as shown in this study would not be greatly changed. They would be greatly changed only if, in the above instance, more of the population of Lake County, but no more of the present hospital beds, were shifted from one area to another. Analogous situations are to be found in all the other areas.

By and large, when people from several areas discussed the hospital service areas, the dividing lines appeared to be in approximately the right place. When people from a single area discussed the size of a hospital service area, the lines would occasionally appear not to be in the right place.

Finally, the data at hand indicated that a division of the State into 13 areas would be advisable. A study of the same and additional data would perhaps justify a conclusion that another major possibility is to reduce the number of areas to five in all, with a correspondingly larger geographic territory for each area. In such an instance, the centers for larger hospitals might be Missoula, Butte, Great Falls, Billings, and Williston, North Dakota.

It would appear that the 13 areas suggested, with some minor shifts in the boundaries in individual instances, is the more desirable of the two alternatives. The 13 areas would keep facilities closer to rural and small-town population and help overcome the matter of distance. Whether a future plan of hospital service coordination should be based on the 13 areas or on the five areas suggested above is a problem for further consideration.

PATIENTS ADMITTED TO HOSPITALS

Table B gives some information on the number of patients admitted to hospitals, the number of patients resident in hospitals, and the number of patient-days of service in one year. Usually this was for the period of July, 1944, through June, 1945.

There was a total of 76,722 admissions to the 65 general hospitals in Montana for a 12-month period. There were also 2,264 admissions into the special hospitals. Thus there was a total of 78,986 admissions into all hospitals, including the special hospitals.

In addition to admissions during the year, there were patients in the hospitals from the previous year. Thus there were actually 78,543 patients in the general hospitals of Montana during a 12-month period. This constitutes a number of patients equal to 14.0 percent of the population of the State. It should be realized that some patients enter a hospital several times a year; hence there is a slight duplication in this figure. Nevertheless, this is the first time a figure such as this has been available, and it is reasonably indicative of the extent to which Montanans use their hospitals.

The variation in this ratio by areas of the State is considerable. One area had a number of patients in its general hospitals equal to less than eight percent of the population of the area. Three had a ratio of less than 10 percent, while seven had a ratio less than the 14 percent average for the State.

On the other hand, one area had a number of patients in its general hospitals in one year equal to 22.3 percent of its population. Six areas had a ratio higher than the State average.

The explanations for these differences are numerous and cannot be elaborated upon for each of the areas discussed in this manuscript. It should be recalled that the population figures are those of 1940. Since then there have been changes. The total popula-

TABLE B

PATIENTS ADMITTED AND PATIENTS IN HOSPITALS OF MONTANA AND TOTAL PATIENT DAYS OF SERVICE FOR ONE YEAR CLASSIFIED BY AREAS IN THE STATE FOR GENERAL AND SPECIAL HOSPITALS AND AS A PERCENTAGE OF TOTAL AREA POPULATION AND AVERAGE PATIENT DAYS OF SERVICE

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Areas	Patients Admitted[a]	Percent of 1940 Population	Patients in Hospital[b]	Percent of 1940 Population	Total Patient Days of Service[c]	Average Patient Days of Service	
						Patients Admitted	Patients in Hospital
I	3,773	9.4	3,880	9.7	26,130	6.9	6.7
II	2,978	11.3	3,042	11.5	26,509	8.9	8.7
III	5,484	16.8	5,592	17.1	53,727	9.8	9.6
IV	3,677	9.3	3,726	9.5	33,020	9.0	8.8
V	3,745	17.9	3,811	18.2	27,420	7.3	7.2
VI	5,356	15.6	5,491	16.0	56,610	10.6	10.3
VII	10,656	13.8	10,725	13.9	91,162	8.6	8.5
VIII	3,292	15.6	3,372	15.9	28,981	8.8	8.6
IX	11,862	21.6	12,229	22.3	120,773	10.2	9.9
X	3,746	13.2	3,828	13.5	36,738	9.8	9.6
XI	2,869	7.8	2,929	7.9	27,749	9.7	9.5
XII	9,885	11.0	10,221	11.4	134,850	13.6	13.2
XIII	9,399	16.4	9,661	16.9	97,865	10.4	10.1
State-General	76,722	13.7	78,543	14.0	761,534	9.9	9.7
Special-Area X	1,253	0.4	1,378	0.3	51,398	41.0	37.3
Special-Area XII	1,011	0.1	1,632	0.2	446,093	441.2	273.3
State-Special	2,264	0.4	3,010	0.5	497,491	219.7	165.3
State-Total	78,986	14.1	81,553	14.6	1,259,025	15.9	15.4

[a]Patients actually admitted into hospitals in a 12-month period, usually July 1, 1944 to July 1, 1945, or some similar recent 12-month period.

[b]These figures include patients admitted and those carried over from the previous year.

[c]These figures include days in the hospital for patients admitted and those carried over from the previous year.

tion in 1944-45 was less than in 1940. Hence, the 14 percent, representing the ratio of patients to the total 1940 poplation of Montana, would actually be higher in 1944-45. Without doubt, area IX, Great Falls, had an influx of population. Therefore a part of the 22.3 percent, namely, the ratio of patients to the population of 1940, is to be accounted for by the influx of population into Great Falls since 1940; consequently, there was a larger number of hospital patients. If the population figure for the area had been higher, as it should be, the percentage of patients in the hospital would have been somewhat lower. But part of the explanation for the higher ratio is that the Great Falls hospitals draw patients from outside the area. Finally, the higher proportion of available beds indicates a higher use of hospitals by the resident population.

The small ratio of patients to population in area XI, namely, 7.9 percent, cannot be explained by a decrease in population between 1940 and 1945. Area XI suffered no significant population loss. However, some people are known to go outside area XI for hospital care regularly, especially the Northern Pacific Railroad workers who, when hospitalized, go either to Glendive or to Missoula. Because these workers have both prepaid hospital and prepaid medical care in the Northern Pacific Benefit Association, they can only be hospitalized in one of the two Association hospitals except in extreme emergency. Furthermore, it is probable that the population of area XI customarily uses hospitals to a lesser extent than the people in some of the other areas.

For area IV the low percentage of patients in hospitals is explained, in part, by the fact that Williston, North Dakota, only a short distance from the Montana line, is an important hospital and medical center and serves much of the northeastern part of Montana. Montana residents going to Williston hospitals were not included in the survey, nor was any of the Williston hospital bed capacity assigned to this area of Montana.

The low percentage of patients in hospitals in area I is explained, in part, by low hospital use and also by the need for going outside the area, especially to Missoula.

There are similar explanations for the differences between the other areas in the use of hospital facilities. But it is impossible to explain these differences for all of the areas reviewed in this brief survey. The purpose here is to present the facts and indicate only some of the interpretations. Caution is therefore urged in the interpretation of the figures given here.

The sixty-five general hospitals in Montana furnished a total of 761,534 patient days of service in one year. This was an average of 9.7 days per patient in the hospital. For all hospitals, including the special hospitals, a total of 1,259,025 patient days of service was rendered in one year to 81,553 patients, averaging 15.4 days per pa-

tient. The stay in the special hospitals is longer; hence, the higher figure. There are significant differences in average length of hospital stay in the different areas of the State.

NORMAL AND COMPLEMENT BED OCCUPANCY RATIO

Another measure of the use of hospital facilities is the average occupancy ratio. This figure represents the number of days in a year that the hospital beds are in use. It is the number of patient days of service rendered divided by a figure which is the number of patients times 365 days in the year. This represents the extent of year-around use of all hospital beds. An occupancy ratio between 75 percent and 80 percent is considered full capacity. The remaining 20 percent to 25 percent is necessary for emergency purposes, for refitting rooms and beds for reoccupancy, and for purposes of repair and remodeling.

Table C shows an occupancy ratio of 71 percent for the 65 general hospitals in the entire State and a ratio of 63 percent for complement beds. Thus, on the basis of all the hospitals, their use is at nearly full capacity for normal bed capacity, and adjustments have been made by adding emergency beds as indicated by the complement occupancy ratio. There are, of course, considerable variations by areas within the State. The extraordinarily low oc-

TABLE C

NORMAL AND COMPLEMENT BED OCCUPANCY RATIO FOR MONTANA GENERAL AND SPECIAL HOSPITALS, FOR A YEAR[a], BY AREAS OF THE STATE.

Areas	(1) Number of Hospitals	(2) Normal Average Occupancy Ratio	(3) Complement Average Occupancy Ratio
I	5	77	69
II	5	52	48
III	4	65	63
IV	6	70	62
V	3	86	77
VI	7	98	67
VII	8	75	57
VIII	1	67	67
IX	4	68	65
X	4	40	40
XI	4	68	53
XII	7	76	69
XIII	7	83	76
State-General	65	71	63
Special-Area X	2	73	73
Special-Area XII	2	195	183
State-Special	4	166	158
State-Total	69	92	102

[a]A 12-month period, usually from July 1, 1944, to July 1, 1945.

cupancy ratio for the hospitals in area X is to be explained by the inclusion of the bed capacity of the Lewis and Clark County Hospital. Hospitals in area VI, Miles City, are particularly crowded in terms of normal capacity. Crowding is also a problem in the hospitals in areas I, V, XII, and XIII. The complement bed occupancy ratio shows that temporary adjustments have been made in these areas, though not necessarily in all of the hospitals in each area.

Some individual hospitals are very crowded, even in terms of complement beds. This is especially true of the Baker Elizabeth Hospital at Baker, the St. Patricks at Missoula, the Billings Deaconess at Billings, the Northern Pacific at Missoula, the Sheridan Memorial at Plentywood, the Olson at Scobey, the Northern Pacific at Glendive, the Holy Rosary at Miles City, and the Kalispell General at Kalispell. Some of the smaller hospitals were eventually closed during the period of July, 1944, through June, 1945. Several were temporarily closed after that date. This was due to lack of doctors or lack of nurses and superintendents. Hence, the operating hospitals had to absorb the extra load. This closing or limited operation of some smaller hospitals was distinctly a temporary war time expedient.

PROPOSED FUTURE PLANS

Proposed hospital construction in an area can be of three types. There may be complete replacement in the sense of abanoning an existing below-standard construction hospital and replacing it with a modern building. Secondly, there may be major additions to an already established hospital. Thirdly, there may be construction of totally new facilities in a community previously without a hospital, or an additional hospital in a community already having some hospital facilities.

Table D gives the information for the known proposed changes or additions prior to January 1, 1946, by areas of the State and for general and special hospitals. Figure 3 shows these proposed changes by more specific locations within the State. In seventeen instances there are plans to replace completely the existing general hospital facilities. This is evidence that Montana's present hospital construction problem is not alone one of acquiring additional bed space, especially in areas without hospitals, but is also one of completely replacing existing buildings, in conformity with fire resistance standards, and of providing structures to replace bed for bed. In fourteen instances plans call for additional beds to be added to existing general hospital facilities. In eight instances there are plans for new hospital locations of the general hospital type making a total of twenty-five new general hospitals in Montana.

TABLE D

PROPOSED PLANS AND HOSPITAL BED CAPACITY FOR MONTANA HOSPITALS BY AREAS AS OF JANUARY 1, 1946.

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Areas	Number of Hospitals [a]	Planning Total New Replacement		Planning Additional Beds		Planning New Hospital		Total Additional Beds	Normal Beds	Total Proposed Capacity	Population-Bed Ratio	
		Number	Beds	Number	Beds	Number	Beds				Proposed	Present
I	5	2	80	1	25	0		105	64	169	4.2	2.3
II	5	2	90	0		0		90	108	198	7.5	5.3
III	4	1	40	0		1	30	70	210	280	8.6	6.9
IV	6	4	136	0		1	30	166	72	238	6.0	3.3
V	3	2	65	0		0		65	57	122	5.8	4.1
VI	7	1	30	2	171	0		201	148	349	10.2	4.3
VII	8	1	30	4	165	0		195	314	509	6.6	4.3
VIII	1	0		1	40	1	30	70	119	189	8.9	5.8
IX	4	2	90	0		0		90	434	524	9.6	8.9
X	4	0		1	8	1	30	38	249	287	10.1	8.8
XI	4	1	50	2	38	0		88	86	174	4.7	3.0
XII	7	1	125	1	45	1	30	200	380	580	6.5	5.5
XIII	7	0		2	160	3	240	400	318	718	12.5	5.7
State-General	65	17	736	14	652	8	390	1,778	2,559	4,337	7.8	5.3
Special-Area X	2	1	200	0		0		200	50	250	0.5	0.4
Special-Area XII	2	0		2	230	0		230	628	858	1.5	1.2
Special-Area VI	0	0		0		1	150	150	0	150	0.3	0.0
Special-Area VII	0	0		0		1	100	100	0	100	0.2	0.0
Special-Area I	0	0		0		1	40	40	0	40	0.1	0.0
State-Special	4	1	200	2	230	3	290	720	678	1,398	2.5	1.5
State-Total	69	18	936	16	882	11	680	2,498	3,237	5,735	10.3	6.9

[a] As of August 1945.

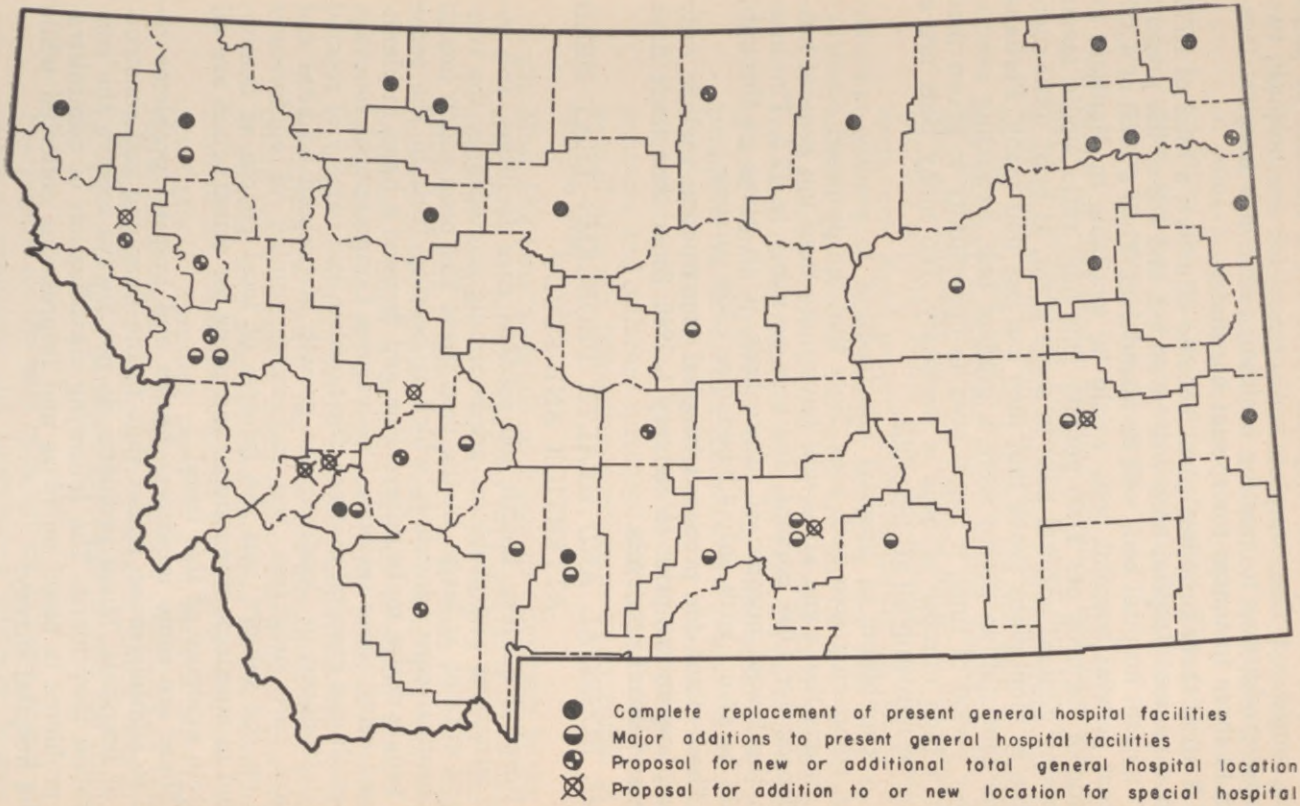

Figure 3. PROPOSED FUTURE CONSTRUCTION OR ADDITIONS TO GENERAL AND SPECIAL HOSPITAL BED FACILITIES IN MONTANA AS OF JANUARY 1946.

Likewise, for special hospitals there are a number of plans being considered: One complete replacement for one hospital; two extensive additions to existing buildings; and new hospital locations in three instances for special hospitals.

If all of these proposed plans become effective, a total of 1,778 normal general hospital beds will be added, and 388 of the present 2,947 normal hospital beds will be abandoned. Thus a total of 4,337 normal general hospital beds would be available in Montana at a ratio of 7.8 beds per 1,000 people. This high ratio would mean too many general hospital beds in some areas, at least until such a time as Montanans prove that they can use that many. Perhaps if the construction period were a gradual one, extending over a longer period of time, it might give an opportunity to prove that such a high number of beds is necessary. Too many beds are a financial hardship on all hospitals.

Over-ambition in hospital construction is readily apparent when comparing area with area. Note that the proposed construction means that some areas will have more than ten general hospital beds per 1,000 persons, one area as many as 12.5. The area with the lowest number of future beds, if all plans go through, would be area I with only 4.2 beds per 1,000 persons.

These plans for proposed hospital construction include only those plans known prior to January 1, 1946. Since then there have been additional proposals.

SOME HOSPITAL AND HEALTH PROBLEMS THAT NEED ATTENTION AND STUDY

Hospital matters, health and medical care facilities, and related situations and problems are becoming increasingly the concern of citizens at large. In the past there has been much health and medical care education, which is bearing fruit in the sense that people desire more information and demand a hand in planning and using these services. The various Congressional hearings on health and hospital matters, the number and variety of related bills introduced in Congress, the growth of prepaid hospital and medical care programs, the increasing number of conferences held on the subject, and the interest of local people as demonstrated in meetings, discussions, and plans for construction are all concrete evidence of this trend.

There are some important health and hospital problems related to administration rather than to the financing and construction of hospitals. These problems do not always receive the consideration they merit. The following classification of administrative problems is based on ideas and impressions collected while on the hospital survey:

(1) Montana does not have a hospital inspection law and program other than that for maternity facilities. Conditions in some hospitals warrant the creation of a general inspection law and its rigid application. The raising of hospital and medical care standards in Montana seems to require an inspectioin program.

(2) Some of Montana's present hospital bed capacity, especially in the smaller hospitals, is used for the housing of aged who are not really hospital patients. However, some of the proposed future hospital construction is based on the general recognition that housing facilities for aged who are homeless but not hospital patients are necessary and the popular belief that the hospital is the place for such care. Aged people, who frequently do not have full control over their mental faculties and who may be unable to get around but who are not in need of remedial and curative care, should not be housed in the same quarters with patients receiving such care. To do so is medically and administratively unsound. Unnecessary confusion, problems of the care of patients, and problems of retaining nurses in such instances make it absolutely necessary that the aged not be kept in the hospital proper, but in separate and adjacent quarters and that minimum standards of care and inspection procedures be extended to this service also.

(3) Most Montana hospitals, as hospitals elsewhere in the Nation, have no public relations program. It is most important that hospitals in Montana develop a sound and extensive public relations program, so that factual and informed public opinion can replace gossip and uninformed comment. Such a public relations program should also bring justified critical comment to the hospital administrators and hospital boards. A good public relations program functions both ways, and both the administration and the public have much to learn about the proper functioning of hospital and medical care facilities in the community. Most of the Catholic hospitals and a large number of the non-Catholic hospitals need to give serious attention to the establishment of hospital boards consisting of laymen representing all community interests. Such boards can be effective links between the hospital and the community.

The failure on the part of hospitals to have sound public relations programs and functioning advisory boards has

contributed to deep-seated conflict within some communities or is a potential for conflict at the slightest disturbance. Unfortunately this actual or potential conflict arises when there is either only a Catholic or only a non-Catholic hospital in the community and the community is not large enough to maintain two hospitals. Occasionally difficulties arise when there are several hospitals in the community, both of the Catholic as well as the Protestant type, but the medical staff in all (or in some) is of the closed type. In at least one instance the proposal is to build a new hospital to get around these conflicting situations. If these plans go through the result will be an unusually excessive number of hospital beds in the community. In all instances these difficulties can be avoided and overcome by a sound public relations program and an advisory board of lay citizens.

(4) Many hospitals in Montana, especially the larger ones located in the larger urban areas, have apparently paid little attention to the conditions and needs that prevail in the rural and small-town areas. They have been an important factor in bringing the doctors to the city and causing many rural and small-town communities to be without doctors. In short, the point of view in these hospitals has been almost exclusively an urban one. Since hospitals have been crowded and understaffed, they have had their own problems to worry about.

It would appear that town-country relations is a subject that has not been considered and studied by urban hospital administrators. Again, rural and small-town areas have perhaps been far too passive and, in instances, too non-cooperative to work out their mutual problems with the urban centers. This field of town-country relationships is one requiring much study and thought and also some action. The population and interests of the rural and urban groups in an entire area must receive consideration. Many small towns and cities, previously dependent upon the larger center for hospital care and doctors, are planning to build hospitals. One of the chief reasons is to attract doctors.

If these plans are all allowed to develop, many areas will have too many hospital beds; as a result, the large and the small hospitals, the urban and the rural hospitals, will have financial difficulties. It thus becomes necessary that the urban centers, where the hospitals and doctors now are, consider seriously their responsibility and rela-

tionship to the rural and small-town communities. Montana needs to study its existing hospital and medical facilities on an area-wide basis, with emphasis on town-country relationships, before final construction plans are developed.

(5) Montana hospital administrators need to learn more about their duties and about the relation of the hospital personnel to the medical staff. The hospital and medical people of the Nation have developed the well known rules of the American College of Surgeons for Hospital Administration. These make it possible for a proper division of labor between the two groups. Few Montana hospitals actually operate according to these rules. That they do not is reflected in the type of hospital service rendered. In counties and communities where there are several hospitals there is a greater tendency for these rules to be in effect. In counties and communities where there is only one hospital, the American College of Surgeon Rules apply less clearly. In such instances there is also a tendency for the County Medical Association and the Hospital Medical Staff to be one and the same. At least the distinction is not clear.

This situation does not mean that every county should have at least two hospitals. It does mean that hospital administrators must resort to using the rules established to administer a hospital, namely, those known as the American College of Surgeons Rules for Hospital Adminministration.

Perhaps it is also desirable that Montanans ask their legislators to remove the Thompson Law from Montana's statutes. This law virtually ties the hands of a good hospital administrator in Montana.[11]

(6) Many Montana hospitals have contracts with private concerns and public agencies to render hospital care on a special contract basis. This arrangement may include lumber or mining concerns, railroads and telephone companies, other types of manufacturing and business firms, and contracts with counties for the care of the needy and aged.

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[11]The Thompson Law requires that the non-tax-paying hospitals must accept the patients of any licensed medical practitioner. The American College of Surgeons Rules for Hospital Administration require that the medical practitioner make annual application to the hospital administrator to practice in the hospital. In Montana, the Thompson Law thus makes inoperative the rules of the American College of Surgeons. Perhaps the conditions that called forth the passage of this law in Montana no longer apply, or other measures should be used to control the situation for which it was created rather than to tie the hands of effective hospital administrators.

Many of these contracts are old, established at a time when medical and hospital care were less costly, and minimum service was furnished. Generally this service is also obtained at a price less than actual cost.

Most hospitals find these contract arrangements burdensome and expensive. It becomes necessary to charge the private patient a greater amount in order to pay for the total service rendered by the hospital.

Now that hospitals need to operate on a more business-like basis than previously, it would appear that all groups and individuals should pay their share of the legitimate cost of hospital care, including adequate payments by the county for county care patients. There seems to be little justification for the present and traditional practice of having only some groups, and especially private patients, bear the burden of medical and hospital care for other groups in society. Especially is this true when the groups now having contract hospital care on a less-than-cost basis are in a better financial position to carry the full cost than are many private patients. The existing practice is to transfer some of the cost from some groups to other groups without awareness on the part of the latter that this is being done. Thus, it would be desirable for all hospitals to get together and deal with this problem in a uniform manner and correct the situation. Certain communities plan to build a new hospital on the strength of getting the contract of some agency or concern, a contract generally held at a loss by some other hospital in the past. There is, of course no reason to believe that the agency or concern might not change its allegiance again in the future and thus cause all hospitals in the area to suffer.

(7) In planning new construction, the changing population pattern should be closely observed. Areas III, IV, V, VI, and VII lost heavily in population between 1920 and 1940, and in some areas this decline continued after 1940. Areas I and XIII have experienced considerable increases in the number of old people in their population. Some of this increase may be due to a migration of aged persons to western Montana.

The above are some of the larger issues that have a bearing on the effective administration of hospital service after the hospital has been constructed. Perhaps these matters should receive first consideration when deciding whether or not to build a hospital. The problem of obtaining public funds to construct a hospital is a minor one compared with the pressing character of the above problems in their effect on efficient hospital operation.

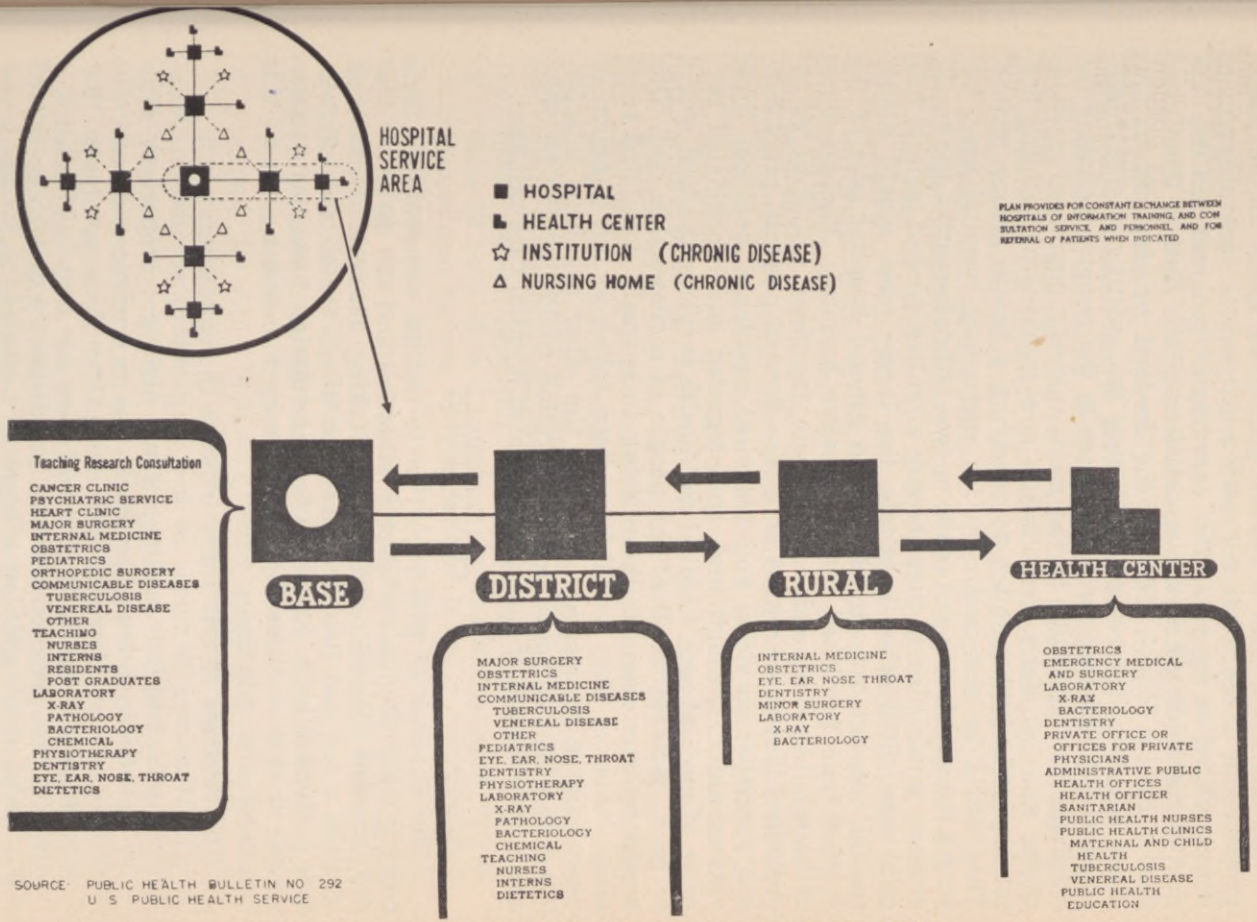

Figure 4. COORDINATED HOSPITAL SERVICE PLAN

In this connection reference should be made to the recent proposal for a coordinated health and hospital care program as demonstrated in figure 4. This coordinated program has the support of the leading hospital associations of the Nation, the United States Public Health Service, the medical people, and various other agencies interested in bringing the existing health, hospital, and medical care facilities closer to the people, including the rural people, especially in the more sparsely populated portions of the country. Many communities now thinking of building hospitals should perhaps plan to construct a health center instead. This would be designed only for emergency hospital care, but would house a doctor and nurse or two. Other hospitals, the smaller ones, would plan to furnish only a limited type of general hospital care. Still other hospitals, the larger ones, would render special hospital care in addition to general hospital care of the limited type furnished by the smaller hospitals. Various types of hospital services and medical care functions would be so coordinated that there would be a free flow of patients, practitioners, specialist services, and technical assistance between these various units. Through such an integrated and coordinated program of medical care, hospital and health services, the best would become available to all of the people at a reasonable cost. This would be true even for those living in sparsely populated rural areas. A major step would have been taken in the direction of town-country cooperation. Some of the other problems interfering with effective hospital administration could likewise be overcome with the aid of such a coordinated hospital care program.

CONCLUSION

The purpose of this report is to outline some of the facts bearing upon Montana's hospital situation and the direction that the proposed hospital construction is taking. There is no intention to make a full and final interpretation of all the factual information presented here. Requests for information have been so extensive that the writer felt it necessary to release some of this information at this time.

The findings of this study indicate the following:

(1) Measured in terms of bed facilities to population, Montana hospital facilities rank high in comparison with available indexes for the Nation as a whole and most other states. However, this fact alone does not mean that Montana has sufficient and adequate hospital facilities.

(2) Certain areas of Montana are distinctly underhospitalized and need additional hospital facilities, to be on a par with the rest of the State.

(3) Not all the present facilities are in the proper location with respect to needs within the State as a whole and within the individual areas. This is true even of areas with a high bed-population index. The predominantly rural areas are especially neglected.

(4) Many of Montana's present hospital bed facilities are housed in buildings that should be abandoned, since they are very old and non-fire-resistant, were never originally intended for hospital purposes, or are inconvenient and embarrassing from the standpoint of location and hospital service and administration. This is true of some of the larger hospitals of Montana, where some of the best medical care is offered; but is more frequently true of small hospitals. This below-standard hospital construction can be measured by the fact that, for proposed plans, seventeen buildings, now used for hospitals, are to be completely abandoned for hospital purposes and new buildings are to be constructed. The abandonment involves a total of 388 present normal beds, which are to be replaced by 736 new beds. There are also a number of additional instances where beds, or buildings or portions thereof, would be abandoned if hospital inspection were a fact, but where the operator and the community at present are not aware of the need for abandonment.

(5) Montana also has a large number of small hospitals, too small for economical operation. There are 30 out of a total of 65 general hospitals with a normal capacity of fewer than 25 beds. This is considerably smaller than the 50 bed lower limit for size of hospital that is being recommended by those who know the cost of hospital care, the need for keeping down the cost to the patient by spreading the fixed overhead over more service, and yet furnishing service that will attract the patient.

(6) If present hospital construction plans all materialize, it does not follow that the present inequities will be corrected. In some instances, such inequities will become less pronounced; in others, they will be intensified, or at least continued.

(7) There is a need for studying present facilities and proposed construction, not just from the standpoint of the single community, but in the framework of an entire area and from the standpoint of the total State situation before finally going into a construction program. A Statewide plan is needed as a guide for hospital location and distribution.

(8) When plans are made for hospital construction, the problem of adequate financing is important, but that of financing current operations is still more important. Furthermore, there is a real danger in so over-emphasizing the problems connected with construction that little or no attention is given to the problems of operating hospitals. These problems of hospital administration resolve themselves around the following issues: The need for establishing hospital standards and a system of inspection to get the services up to minimum and desired standards; the need for segregating the ambulatory aged from other hospital patients; the need for encouraging rural and urban cooperation in hospital matters; and the need for bringing contract payments for medical care into line with private payments, and nearer actual cost.

(9) To obtain the most effective care from existing and proposed hospital facilities, Montanans should urge their legislators to do four things during the coming legislative sessions. These are:

(a) To pass a hospital standards act with sufficient power of inspection.

(b) To repeal the present Thompson Law.

(c) To pass enabling legislation and designate a State agency to receive and administer Federal funds for hospital construction, especially those funds made available by the recent passage of Senate Bill 191. This act is also known as Public Law 725—79th Congress, and as the "Hospital Survey and Construction Act."

(d) "Put teeth into" the inspection procedure for old people's nursing homes and institutions that take care of aged only. Failure to do this will result in the fact that certain institutions, denied a hospital rating, will function as nursing homes for aged but will furnish some hospitalization service.

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ERRATA

Page 6. Figure 1—The boundary line between districts II and III was omitted. It is the same as the county line between Liberty and Hill Counties.

Page 21. Figure 3—The location of one symbol representing "the complete replacement of present general hospital facilities" was accidentally left out. There should be such a symbol in Musselshell County.