MR. CHAIRMAN: Resolution 54 1 (a) passed.

MR. SHOEMAKER: Mr. Chairman, when the committee rose at 5:30 I was attempting to prove two or three points and probably I should summarize what I intended to leave with the committee. One was that it is a fact, it is a fact that there is an overcrowding in the acute hospitals at the present time and that, in the words of some of the doctors that I've talked to, about 50 percent of the patients presently in the hospitals could be served as well in other types of facilities -- alternative care-- thereby reducing the cost of the plan and providing more beds for the acute cases. And then I suggested too, that the grants that are presently made available to hostel care or alternative care or whatever term you want to apply to it are too small to encourage any further development in the field of alternative care. Now this session we have no one writing "under the Dome, but I have an Under the Dome item of July 1959 when the Honourable Minister is being reported on, and he may deny some of the statements that are in here, but he suggested at that time -- and this is reported Under the Dome, ENS July 1959. "Dr. Johnson's program"-- and this is the program for alternative care, elderly persons housing, and so on -- "Dr. Johnson's program builds on the premise which was also incorporated in the legislation to set up the Provincial Hospital Plan that sick people, especially the chronically ill, are not necessarily best cared for in a hospital. It accepts that a sick person who can be cared for as well elsewhere should be persuaded to leave the hospital and free the bed space for patients who genuinely need active hospital care. The directorate's awesome job is to co-ordinate all of the services, professional and voluntary, in the local community and over the province at large, that are necessary to provide the right care for each individual patient outside the hospital." So it does appear that my honourable friend was quite in accord with what I have said up to this point on this subject matter.

Earlier last week I discussed this matter with the Associated Hospitals of Manitoba, and I know my honourable friend agrees with most of the comments coming from that very august body, and I received a letter from them March 22nd, the same date incidentally that it is on the two sheets that were laid on our desk this afternoon from his department -- and I should read this. They do disagree with me slightly, but not very much, and here's what the Associated Hospitals of Manitoba have to say: "Dear Mr. Shoemaker: Re: Alternative Care Facilities for Long-Stay Patients". This is the title. "In reply to your inquiries of the association, I wish to advise you of the general comments of our organization on the above subject as follows. The association agrees that (1) there continues to be a shortage of beds in acute general hospitals, particularly in the metropolitan area. (2) there continues to be many patients occupying beds in acute general hospitals that might be termed "long stay patients" by the nature of their afflictions and that might be as well served in a proper and adequate home designed for alternative care at considerably less per diem cost out-care. (3) there should be an approach made to more adequately overcome these problems by establishing alternative care facilities. The association however, disagrees that (1) There is a necessity to immediately effect comprehensive government coverage for all persons receiving alternative care outside acute general hospitals and that costs for such care should immediately be included under the Manitoba Hospital Commission. My personal observations on the above matter are that (1) There are a very limited number of proper and adequate homes in the province designed for alternative care, which at a lesser cost provide equal or better opportunity for patient recovery then does the acute general hospital. This limited number is restricted to those institutions who are operated on a non-profit basis by voluntary and religious organizations and who are more closely affiliated with the hospital field. In fact the most satisfactory development approach would be to have all alternative care facilities affiliated with or operated by the administrative bodies who run the acute general hospitals. (2) Providing that the province assumes financial responsibility for all indigent patients that hospitals have a facility to which they can move the long stay patient upon termination of treatment in an acute basis; and that the facility to which the patient is moved is in effect an extension of the care given from time of admission to the acute general hospital. It would be reasonable to suggest that coverage under the Manitoba Hospital Commission could be extended accordingly; however,

(Mr. Shoemaker, cont'd.) . . . . with such ground rules established there are many existing facilities with occupied beds where Manitoba Hospital Commission coverage is not and should not be made available. Also any direct admissions to alternative care facilities where treatment in an acute general institution had not preceeded or prompted the admission should not be given coverage under Manitoba Hospital Commission unless the patient was admitted by his physician or physician consulted by his doctor to an alternative care facility affiliated with or operated by an acute general hospital and in which the admitting physician is on the medical staff of the hospital and or alternative care facility. (3) Manitoba Hospital Commission coverage should be available only where it is medically necessary for a patient to be treated in an adequate facility designed for the purpose of such treatment and should not be extended to domiciliary care in any institution. I trust that our comments will be of interest to you. Signed by the Executive Director of the Associated Hospitals of Manitoba".

Now, Mr. Chairman, I have never suggested that . . . .

MR. ROBLIN: Mr. Chairman, may I ask my honourable friend to table the letter please?

MR. SHOEMAKER: Okay. Mr. Chairman, I wonder if I could get a copy of it (Interjection) All right. It's dated March 22nd, 19 (Interjection) Mr. Chairman, they can give a copy to every member of the House as far as I'm concerned, it doesn't -- two copies my honourable friend says. It's all right with me. I never suggested that every patient in every nursing home should be covered; I don't expect the plan should do that. But where in the opinion of the medical profession, as my honourable friend agrees, that the patient should be removed from a hospital bed to provide space for someone who urgently requires it, then I think it should be paid as suggested in the advertising that is sent out by the Plan.

Now, Mr. Chairman there are two or three questions that I would like to ask the Honourable Minister, and I'm referring now to the sheet that was laid on our desk this afternoon, the single sheet. Under Miscellaneous Income, I would like to know what that does include. My guess is that it covers the semi-private and private ward care that the patients pay when you enter a hospital. If you go into a Winnipeg hospital today and demand semi-private or private ward care, I understand that that produces something in the neighborhood of a million dollars, I thought for the plan, so it probably does not include that item there. Then again--I think this question was asked and my honourable friend may have given the answer--and that is the amount of money that the hospital tax--the figure that it will produce for 1962. In looking at the second item: Grants from the government of the Province of Manitoba for insured services and other hospital care", it jumped $7,225,000 from '61 to '62, so the question is does the $7,225,000 --does that represent what the government expects to receive from the hospital tax?

MR. JOHNSON: Mr. Chairman, I guess I should try and catch up with some of the questions here, and as I said when I introduced my estimates I had hoped to deal with the health section, make a statement on the Hospital Plan and that way get through my salary or I could have put a caveat on that, that we could always come back until the hospital plan statement had been made and this had been dealt with. However, members have chosen to cover the field and I hope that I have been able to keep track of all the questions asked and to indicate to the committee some of the answers to these questions adequately. The thing that stands out however, and but for the contribution from the Member for St. John's, disturbs me a little bit in view of my opening statement -- and that is that we seem to be placing most of our emphasis in committee on the creation of institutions, the numbers of same, the management of same and so on. And I think that this committee should be concerned, if not more than any other aspect of health services, with the preventative program and the ways and means of keeping people out of institutions. I think, and with all fairness to members of the committee, it is something that we must constantly keep before us in the health field today. I'm always afraid that the hospital plan or hospitalization could become the cancer in the health care field. The responsibility we have in this committee and in the operation of the Hospital Services Plan is to produce that happy balance of facilities, preventative, curative and certainly we have to work hard to be certain that we have this happy balance. And from the day the plan came in this is the objective which the staff and the department and commission level -- we were most cognizant of this whole area and have constantly, we think, been getting closer to the solution after four years and five years of hard work. However, I would

(Mr. Johnson, cont'd.) . . . . just like to make that point to the committee -- we've often said the easy thing is to build 900,000 beds, one for every Manitoban, and we'll all crawl in. And I'm not saying that facetiously; this is a very real danger that we have to keep in front of us. This is what -- the Manitoba Hospital Survey Report was an attempt to determine what are the needs over the next few years and how should we tackle it within the resources of the province -- resources and grants and so on -- and how should we besides try to catch up and develop those acute facilities that medical science is forcing us to achieve at an ever increasingly faster rate, because of the advances in science, we at the same time have to maintain our current program -- in other words break out into new programs from the old. We have to be sure we don't overbuild in one area at the expense of the other. I just say that the debate seems to be centering around this costly field of institutions and I think that we more and more, in trying to develop as the Survey Board did in looking at this matter, a balanced and integrated hospital system for our province, at the same time we have to pay proper attention to the matters raised by the Member for St. John's -- home-care -- the whole field of geriatric care is coming into focus more and more and the problem touched upon by the Honourable Member from Neepawa.

But I think that we have made a great deal of progress. It is true, as mentioned this afternoon, that I was a country sawbones, but I never had the pleasure of practicing medicine under a Conservative Government. I came in with the Plan. In the old days we -- there weren't too many of the patients who -- in my particular area you had to think twice before you put a patient into the hospital. You had to make 5 to 10 house calls a day to maintain your folks in their homes and in the community, because they didn't have the resources for the high cost facilities. Old age pensions were then $40.00 a month. There was no staff in the hostel with a 20-bed infirmary where I attended, and we had these very real problems, especially in rural Manitoba with smaller hospitals. And it is -- let's face it -- let's look back and let's appreciate what has been developed with the resources made available through the Hospital Commission. We have been able to sit down, at the time of the Willard Survey, with all these several communities, the members of the board, the people in the community, discuss the future of their facility with them, and in planning for the future, developing in those areas that showed the need and the resources, the modern 1962-1963 hospitals, which are a far cry -- a far cry from the hospitals of the old days. The Honourable Member from Neepawa hit on it, you don't build an acute hospital bed today for other than between $15,000 and $25,000. And with costs like this we say to ourselves, well when we're really sick we deserve and we should have the best in facilities and certainly it is up to government to explore carefully that whole area below the plan. These acute beds are our premium beds; they have to be our premium beds and we have to look below the plan and see what we have.

I can tell the committee that it was a shocker to me on the day on which I took office and had a survey made of the 400 chronic beds below the plan, to find 200 people in our chronic facilities who didn't have a home to go to in the terms of the then examiner, Dr. J. D. Adamson. This flushed up the problem, just what was this problem below the plan. It started right down in housing, said the Commission. Housing is important to the Hospital Plan. Elderly persons' housing was stepped up; a full-time director was obtained to develop housing under the formula with the increased grants; and the grants were there, they were enhanced to try and promote this further. Again the same feeling toward hostels. Whereas CMHC funds were available for housing, they were not available for the hostel kinds of accommodation. And then we began to examine the hostels and we began to say in creating hostels should we have infirmaries in these hostels or should the infirmaries be outside of the hostels. The hostel is a residential care facility for the ambulant elderly folks. So we looked at this; we had a full-time architect brought in to study the area with our director of housing; we put this under alternative care as you recall, and we tried to educate ourselves as well as our sponsors as to the kinds of facilities we should be creating. And this has been -- when the Survey Board Report were looking at the hospital situation, as you recall in the Report, they emphasized the fact -- go slow in this so-called nursing home area because we visualize in the future that the acute hospital will have an extended treatment hospital adjacent to it; that the word "chronic and convalescent" really doesn't signify the kind of facility you want. You want an extended treatment facility adjacent to the acute hospital where medical staff can spill over,

(Mr. Johnson, cont'd.) . . . . where you don't have to duplicate operating room facilities and other high-cost facilities. It was further emphasized that rather than just have a place where the patient can be moved from the acute hospital on the third day of an appendix into the chronic unit, that these extended treatment units should have the emphasis on geriatric care. Rehabilitation concepts should rub off on the staff in this area, and the latest advances in chronic care. And therefore the Willard Commission recommended and the medical profession endorsed this concept and our travels in other jurisdictions convinced us that this was the thing to do for the future. And as you recall, the report said, develop six of these as soon as you can, see how they work out, as pilot projects. We think as you attack long-term illness with this newer concept of care in these extended treatment hospitals adjacent to the acute, where you don't have to duplicate the facilities, etc. -- and as you come up from below with housing and hostels and residential care units, we're not too sure just how big that nursing home area is, and our studies in this field have continued at the departmental level and at the commission level. We brought in experts from England, and we consulted them. Dr. Cousins, whose centre I saw and reported on last session, in England, where this concept has become activitated.

We decided to make a bold new step and develop the rehabilitation hospital, and we decided that this should be located right in the heart of Winnipeg, adjacent to the other acute facilities to avoid duplication of operating rooms and so on, where the whole emphasis should be on these newer concepts of rehabilitation and chronic care. The municipal hospitals who are the pioneers in the care of the chronically ill in Manitoba -- the staff from these hospitals helped us with our concept at the rehab. and sanatorium -- brought in highly-trained staff from the outside. The dean of medicine said to us, we're 17 years behind in rehabilitation. Unless we get the concepts of rehabilitation and activity programs we'll never build enough beds. So we made that, if you want to call it, a calculated risk. We spent 4.8 million, or the Sanitorium Board did in developing this facility; and it is one of the finest, I am told on the North American continent. Our commissioner who went to New York recently to examine a situation there that was of interest to us reported that nothing in that great city that they saw matched the kind of facility we had here. The other warning at that time was this. If you did create a large number of beds without a rehab. hospital, without this changing attitude towards the care of the ill, that you may find yourselves without the staff to staff such large facility; that doctors don't tend to leave their acute hospitals and drive out some distance to visit the chronically ill; that if you're going to keep these active and the kind of facilities you have in mind, we think you should approach it from this way. So the decision as we all know, we went ahead with the rehab. It's now functioning. The concept of care that they are developing, and at the municipal hospitals, is a first-class kind of care, and something which all Manitobans can be proud. In addition to this, we at the hospital commission level decided in developing extended treatment hospitals, we formed a chronic care committee -- a committee of experts from the commission, the rehabilitation hospital, the director of the municipal hospitals, and they have gone out to places like Morden, where these extended treatment hospitals are going into operation, and working with the doctors in the region to point out the kind of facility and the kind of care we hope that these units will develop; that they be places of activity in helping the patient, those patients who can be brought back to the maximum of their capability. I think we have to, its incumbent upon us to know that this kind of thinking -- this is the over-all plan from the commission level. So as the Willard Commission, that group of people, advised us in this manner, so the Welfare Department pushed away at the hostel and housing program. I thought it might be of interest -- I added this up the other day for a talk which I gave to the group at the municipal hospitals -- and there are now 2,609 elderly persons' beds in operation in Manitoba. 216 residential care hostel units have been created in the past year -- in '62 and 176 housing units, and a further 279 are presently under construction. In other words, this is going ahead quite sharply, and this is for the ambulant patient who just needs custodial or domiciliary care.

So the objectives of the commission are therefore to create in the future, on a yearly basis, extended treatment units throughout the province adjacent to acute hospitals for the care of patients who require constant medical and nursing care. That should be our objective. Below that, we come into the hostel and residential, the patients who can be on their own in their own home or in housing units and in residential fraternity houses, the very aged, frail,

(Mr. Johnson, cont'd.) . . . . elderly. And then between these two categories here we call extended care -- now versus extended treatment. It's in this area of extended care, so-called rare area, that we worked so hard with under the alternative care program, and during the past year came to the conclusion with the separation of the Health and Welfare Departments that we both had a very real role to play here, so the Health and Welfare Departments have formed, as you see in your estimates replacing alternative care, the Care Services Division, where our health people will be in charge of the licensing and standards of care facilities below the Hospital Plan and where the Welfare Placement Services will work in equal partnership in this particular area, defining for the departments the kind and licensing these facilities throughout the province -- in Greater Winnipeg our Metro group and through our units and through this group in places where we have no health units. The object of this is that the Care Services will also work closely with the Hospital Plan and the Hospital Plan to that participating in this by paying part of the salary or salary of the Welfare Supervisor of Placement Services. It's becoming more evident, to the commission, in other words, that they have a responsibility below the plan, that instead of hiring a social worker to go around and discuss problems with the social workers in the hospital that this one and the same person could do this entire job and keep the commission informed. A t the present time we've asked the Commission in Care Services to evolve the policy for the future. We may be accused of procrastination; there may be accusals of delay in defining this entire area, but frankly this area has shrunk as we're developing these other facilities. For example when the St. Boniface San was made a hospital facility here a few years back, or two years ago, this enabled an assessment of those patients who were extreme care problems in nursing homes, to be moved into the San for further assessment and treatment and when they no longer need acute or hospital care, continuous medical or nursing care, we try to, through this placement services division we've set up, try to place them back into the community.

As members will recall, when the department took over the rate setting of the nursing homes in 1959, the City of Winnipeg continued to set the licence and set the standards and provide for the medical care services and this arrangement is now being transferred back to the Department of Health so that we have the standards and the rate setting in the one division. However, the Commission felt that they should participate in this exercise to a degree. In this extended care area we visualize the kind of nursing home facility I think my honourable friend fron Neepawa is talking of, and the boarding home kind of facility outside The Housing Act. So we have really therefore five major classifications of facilities that government uses for classifications of facilities that government uses for classifying them according to need: the acute hospital, the extended treatment, the extended care facility, residential home and housing, and I think it's interesting to reflect that 70 percent of the people in these care facilities below the Plan, are in receipt of social allowance.

There is this area of care then that we are continuing to look at and I think a great deal has been accomplished. We pretty well know what we're up against in this area; for example we have come to realize recently the kind of care facilities that should be provided in this area. A number of these people are senile, confused, aged folks who can't quite get along in a hostel and who need a degree of personal care in a personal care home. In many cases they can be cared for in a home care situation, in many cases they can be in their own homes, or they can be cared for in a boarding home kind of situation. We have to individualize to a great degree because of the diversity and the number of physical disabilities that gravitate to this area. However, the whole concept should be, we think, one of activity rather than -- and should be diversified rather than institution centred.

Now the Honourable Member from St. John's mentioned the chronic care and geriatrics. He wanted to know what the Department was doing about it. Well, a great deal has been going on and I think that -- it's such a long story I could probably just give a thumb nail sketch -- in telling you that our hope is in the geriatric field to find that happy balance of health services that I have mentioned, that we have to examine carefully the number of acute and chronic beds we need, extended treatment beds, the number of nursing home kind of beds, hostels and housing. I've indicated what we're trying to do in this area. I also say that the Hospital Plan have, as I mentioned, set up this Chronic Care Committee. The Age and Opportunity Bureau have been doing a great deal of self-examination in this area and were in to see me a few times in

(Mr. Johnson, cont'd.) . . . . the past year. I have, for example, in order to enhance the Chronic Care Committee, have written to the president of the University suggesting he appoint a member of the University to this Committee because I think in the future the teaching of geriatric care should more properly be a priority of the University Medical School. The president has this under advisement. We have, as I said earlier, called in experts like Dr. Lionel Cousins and others to give us their expert advice. We have some very wonderful experts of our own in the borders of Manitoba, at the Municipal Hospital group the doctors there; now at the Rehabilitation Hospital. We want all these in an advisory capacity to the Minister and recommending where our public health people should go to improve their understanding of the problems in this new care field as it opens up in the department. We have also the Commission to look to for advice in staffing of extended treatment hostels and helping the voluntary board staff these extended treatment units; for example, the one at Dauphin that's opening. In this case the Board and the Commission arranged for some of the nurses to come in and spend some time at the Municipal Hospitals and see the attitude and the concepts that we wanted to develop, and they wanted to develop also, both in advisory capacity to the Health and Welfare Departments.

In addition to this, we are hoping, as I mentioned in my remarks Friday evening, of carrying this concept into the mental health field at the same time. We have also spoken to the Winnipeg General Hospital Board concerning the creation of psychiatric facilities at that site with day hospital facilities and so on, which would be incorporated in that. In home care, I can mention to the honourable member that we have -- oh yes, re day care. At the Municipal Hospitals we have, I think -- I think there's 20 day care patients now in a section in the experiment over there for day hospital care for the long-term ill. That's at the Municipal Hospitals. The home care programs -- we had the polio home care program, utilizing federal grants helped us with iron lungs, rocking beds and so on and moved all patients who were able to be moved out of the Princess Elizabeth into their own homes. This happened in '59 and has been continued. The Director of Rehabilitation is on these hard core cases on a special basis making placements and I think we have about 70 people on home care under that program. The Social Allowances Act is supporting, in the Department of Welfare, I think it's over 400 now situations of elderly folk in home care situations with, in some cases, a housekeeper service, in others maybe a VON visiting service. The Winnipeg General Hospital home care program is in the Estimates. They have a number of patients on home care there and this started out as a pilot project in '58. This project has been most successful and in the Annual Report this year the doctors advise me that this probably equals 37 acute beds being maintained or extended treatment beds being maintained in a community by having this hospital-based operation. We have -- I should say, first of all three years ago on the success of our Winnipeg General Hospital program did in our Royal Commission brief at that time, ask the Commission to consider the inclusion of hospital-based home care programs as part of insured hospital services. This is being critically examined at this time by the Hospital Commission because in examining the Winnipeg General Hospital program and so on we are coming to the problem of definition of what constitutes medical practice and what constitutes hospital practice. We have to make this division here of how to support these things in the future. There are some who think to be successful they have to be hospital-based; there are others who feel that this isn't necessarily so.

Our Commission group recently travelled to New York to see the ..... I think it is, hospital there, to see what they might learn from their program. I haven't had a chance to discuss it with them but my impressions were they weren't too impressed. We have quite a diversity in other words of home care situations that have been started as pilot projects that we've been trying to build upon. In the estimates where it refers to medical care this is an appropriation that's been in there since I came in -- under the Health Services Act provision was made under a so-called municipal doctor system where a community have prepaid lab and X-ray, prepaid health unit services and a municipal doctor arrangement, the province bonus them 50 cents per-capita and we have about, I think six or seven municipalities who receive a very small grant under this appropriation. It's still in the Act.

There is another item under here, Medical Officers in Unorganized Territory where we also pay physicians for public health services, immunization and so on in isolated areas orin

(Mr. Johnson, cont'd.) . . . . out-of-the-way places in the Province of Manitoba, such as the northern part of my constituency. There's also an item here of $18,000 which is the indigent program north of '53. In 1959, we in addition to the medicare program and our northern health services, public health service, developed a prepaid program for recognized indigents north of '53 and this service is carried on north of that parallel and the doctors in the whole wide area there submit accounts to our Director of Northern Health Services who keeps the rollex file and pays the account every month and this is working eminently satisfactorily.

The cost of drugs mentioned by my honourable friend certainly has concerned us. I don't know if he's read my remarks re the Restricted Trade Practices Commission Report during the ..... I don't recommend reading Hansard as far as I am concerned, I can never make out what I say in there. I seem to be the most disjointed individual. However, I tried to indicate there some of the thoughts we had on looking at the Restricted Trade Practices Commission Report. I can report for the honourable members' information that within the department we for all our mental health needs, the purchasing agent -- any institution that spends over $1,000 on pills of any one kind, I think it's a thousand, if they're ordering over that amount they must order, we have all three institutions bulk their tenders together and we put it out for tender and this has gone on. Then at the Hospital Plan we have a full-time pharmacist now assisting especially the smaller hospitals with the development of formulary and examining drug costs.

I can point to the Honourable member that the whole question of gerenisity and what have you has been a subject of discussion in the past few months even between the medical profession and ourselves and the Professor of Pharmacology Dr. Nickerson in connection with our medicare program. And of course our submission to the Royal Commission on Health is that in seeking federal assistance what we're thinking of is the examination of these drugs for potency and so on. You do hear the odd criticism which was voiced at the Royal Commission Briefs here in Winnipeg alone that gerenisity tends to sometimes give the inferior product, so we think, and have always thought that a beefing up of the food and drug directorate in the inspection of drugs and the formation of the National Drug Board was the first step. And really at this level our problem is in the organization of drug services for our own use and through the Hospital Plan and working with the profession and developing with them those procedures that would lower the cost of drugs to the public. I know my honourable friend from St. John's said that the doctor's economic situation didn't worry him. It doesn't worry me any more -- of course the doctor's economic situation is of concern I think to all of us in the sense that we — I'm sure he didn't mean it the way I had it coming through over here, because I began to think of some legal bills and probably had the same thoughts of the legal profession. However, I do think we all believe in a fair return for their proper work.

The Honourable Member for Rhineland asked what functions require the Minister's approval at the Commission. Well the responsibilities of the Hospital commission are spelled out in the terms of reference which are in the Act which was passed last year, mainly to develop a balance and integrated hospital system for the Province of Manitoba, to present us with yearly estimates of their requirements to meet the budgetary requirements of the hospitals in the province and to carry out the capital program which they submit to the Minister. Autonomy of local boards -- when we take over hospital boards are autonomists. We share with the board their requests on operating costs and so on and we don't take over. Checks department made on rising costs. Well we have a whole consultant staff now of doctors, nurses, dieticians and these people examine budgets, examine complaints and work with the associated hospital group in this area. As you know, by talking with the boards and with the associated hospitals, and developing realistic cost levels, the department works these through. Changes by regulation this year. These are reported each year with the annual report, the changes in regulations that have been affected during the year. All I can think of of the recess or in the last year was a declaration declaring physiotherapy an out-patient service and extensions of certain out-patient procedures making them available under the hospital card on an out-patient basis -- but notably physiotherapy at the rehab and municipal hospitals in the past year until we get some experience with it.

The other change in regulation, a minor one, or not a minor one, rather an important

(Mr. Johnson, cont'd.) . . . . one to the hospitals which the associated hospitals and the hospital boards had spoken to us about, and which we had appealed to Ottawa on for three or four years, was the right to declare parking lot revenue -- not to declare it off-set revenue, to allow each hospital board for example to amortize its own parking lot. Previously the federal regulation required us to put this into the hospital budget, or to declare it off-set revenue. This kind of thing has gone on this year. Comparative statement, only one you're getting. Well this shows the total cost. Do you want to go into details -- well I just ask myself, how much detail we can get into. These represent insured hospital services and the capital payments that are made to hospitals throughout the province. With respect to his own constituency, with Altona. The situation in Altona is that -- as I recall the -- they've been authorized to proceed of course with their building program which includes an 18 bed nurses' residence and the renovation of a portion of the present hospital. The original tenders came in far too high, and the commission and the board met and made a readjustment of costs and this is going forward. The Winkler Hospital has been approved as the vote carried by 94% majority and I'm sure they'll be going ahead at any time.

I should enlarge on the remarks I said re the last question here, but anyway, the commission recommends to the Minister in respect of each year an operating and capital budget for the hospital insurance program and this implies that the entire budget must be approved by the Minister, of course, and in 1963, $10,643,000 of the total budget are included in the estimates. I can't think of anything else with respect to that matter. However, I do want to, before sitting down mention the fact that in the development of acute and extended treatment hospitals where we have firm grant structure, firm policies laid down, and also with respect to 12 residences for the aged and infirm, that as we look at this nursing home area jointly between the commission and care services should remind our honourable members that in the present facility, the Social Allowances Act is providing assistance to 70% of these people in this kind of facility. Since 1958, we must recall that the extended treatment hospital capacity has been expanded by the Brandon Assiniboine Hospital of 200 beds; the St. Boniface San. by 180 beds; Clearwater at The Pas 58; at Dauphin 35; Winnipeg Municipal 40 for a total of 513; and in addition to this, a total of up to close to 900 or 890 extended treatment beds are in the stage of planning and development at the present time. However, we are continuing to give this so-called grey area our fullest attention in the development, and we have, as I say been accused of being slow in this area. However, we must remember that the move we make at this time in this particular area is -- in creating the kind of facility we've never been just sure what sort of facility we should create to meet the need in is important in view of the fact that this is the pattern of care that's going to be adopted and followed in our province for the next 40 to 50 years, and before developing the extended treatment and residential programs to the fullest we weren't just sure how big this so-called area would be. However, it continues to hold our attention.

The honourable member has asked about the sheet I distributed this afternoon; the premiums earned. I think he wanted to know miscellaneous income. This is made up of largely third party recoveries and interest on monies in temporary deposit and so on. That's the $110,000 and — the third party recoveries I should say for '62 -- they're higher than they are in '63 because the 1962 includes a great deal of the money which would under other circumstances have been collected in '61. As you recall the Act was amended in '62 because of difficulties encountered in its application and many claims had to be held through '61 until the amendment was enacted in '62. That's why there's a drop in this particular phase of it.

The semi-private and private accommodations referred to by the honourable member doesn't show in here and I don't know if he understands that and I don't know if I'm capable of understanding how we deal with this but, as you recall, at the time the Hospital Plan came in, it was the decision of the Associated Hospitals and the hospitals themselves, that they retain — this is called preferential accommodation revenue -- and they were asked how they wanted this managed and they decided they would keep half of this preferential accommodation income back over and above the standard. Now every hospital has to have half its capacity in standard beds. In providing semi-private and private accommodation this extra revenue received half of it is retained by the hospital and is taken into consideration at the time of setting their budget. The other half comes to the Commission and this is used mostly in the payment back to the

(Mr. Johnson cont'd) ..... hospital of their capital — outstanding debentures and so on; and least year if you recall the decision was made by regulation to give 10 percent of that back to the hospitals, of our 50 percent, to enable them to purchase special equipment for special projects and so on; and consideration is being given to increasing that a little further to give them a small operating revenue.

MR. PAULLEY: .....I want to say that last Friday evening we heard from the Minister quite an oration and it seemed at that particular time, to me at least, that the Minister was quite pronounced in that what he was doing was a good job, that the Province of Manitoba was first in a number of instances and my honourable friend was most vigorous in his defence of the Department of Health and the activities of the Minister and all of those associated with him in his Department. -- (Interjection)-- Yes, other than the Minister.

But I want to say to him tonight, Mr. Chairman, that I am absolutely disappointed with him because it seemed to me as I listened to him tonight that tonight he was full of apologies for what they are not doing; that the firsts that he was talking about last Friday evening have now become the last. I was particularly interested in my honourable friend this evening talking about the "grey" area. I suggest to my honourable friend that he should make amply clear that the grey area that he was talking about is spelt g-r-e-y and not g-r-a-y, my colleague from Inkster. Because in the field of --g-r-a-y -- it appears to me from the enunciations of my honourable friend, the Minister of Health tonight that he has gone so far away from the firsts in Manitoba and the firsts that are required in Manitoba that it's almost humorous, if in the important field of health there is any humor, that it's almost laughable. My honourable friend, the Minister of Health, as I say, on Friday evening was quite vigorous in the defence of his department. Tonight I think that he has opened the door to the deficiencies in the field of health care in the Province of Manitoba; and I would suggest to my honourable friend that in the grey area, instead of talking about the calibre or the differentiation in color, that he talk to my honourable colleague, the Member for Inkster, whose name is also of course Gray, in order to get the full needs of the people of Manitoba in the field of health.

My honourable friend mentions the fact in his remarks this evening -- and I must say that as far as I'm concerned he travelled the waterfront -- he went all the way from psychiatric treatment into the field of elderly citizens' homes and then back again, touching a little bit on our mental institutions and then he went hither and yon. I'm going to be most interested, and I'm sure that most of the members of this House are going to be most interested, if we can find the time in this very brief session or -- well it appears to be rather a brief session -- if we can find time to be able to cover the field of endeavour of my honourable friend the Minister of Health as will be recorded in Hansard tonight, because it appeared to me, in listening to my honourable friend, that in most of the instances that he was talking of tonight, in the field of alternative care, in the field of elderly citizens' housing, in the field of care of our elderly that he was bringing about a connotation of the necessity of welfare in respect of the people who are elderly and requiring aid. I suggest, Mr. Chairman, to the Minister of Health that rather than, as he appeared to me at least, to bring about this connotation of the association with welfare to our elderly citizens that it's time the Government got up off their -- onto their feet -- I almost said it -- that they got onto their feet and come to the realization that the elderly citizens in the Province of Manitoba do not want any connotations of their care with that of welfare, but what they want is to be able to have in the twilight years of their life, proper care -- as a right.

My honourable friend, the Minister of Health, mentioned the field of home care. Again when he was talking he brought this in again -- the connotation of welfare, and I suggest to my honourable friend it might be unfortunate as far as he is personally concerned that the Government of the Province of Manitoba did not see fit a few years ago to separate the Departments of Health and Welfare. I appreciate very much the fact that the present Minister, the Honourable George Johnson from Gimli, is the Minister of Health, but I suggest, Mr. Chairman, that he is still carrying along in his thinking and in his mind this association with welfare insofar as our elderly citizens are concerned; and I can appreciate his difficulty in trying to disassociate himself with his previous practice here in the Province of Manitoba. I suggest to him that instead of all of the firsts that he told us on Friday night, that he and the particular department -- and I dispute that most of them are firsts -- but despite that I suggest to him that he get out of the mannerism that he has of these "firstisms"; that it's not the truth, because other jurisdictions

(Mr. Paulley cont'd) ..... have gone far and beyond in the field of geriatric care, in the care of our elderly citizens. --(Interjection) -- I'll name it! You're darn right I'll name it. The province to the west of you. And I would suggest to my honourable friend, the Minister of Health that he take off his rose coloured glasses, as I've mentioned before, and put on his reading glasses; and I would suggest Mr. Chairman, that if my honourable friend did this he would be able to read the fine print and see what has been done in this most important field. And I would say to my honourable friend that instead of standing up in this House and talking as apparently he did this afternoon, or this evening as I heard, about the necessity of expansion in this field and that field, and instead of attempting to associate welfare with the needs of our elderly citizens that he come down to basic realities and face the situation as we are now confronted with here in the Province of Manitoba and do something about it, I think it would be far more to the credit of my honourable friend than the dissertation that he gave us here this evening.

As I look at his estimates, in the field of services to our elderly citizens, I find that they are failing completely the needs of our elderly citizens here in the Province of Manitoba. I find, as I look at the estimates, in most circumstances there are reductions in the field of alternate care for our elderly citizens, and I suggest to the Honourable the Minister when he's replying to pertinent questions such as those raised by my honourable colleague from St. John's that instead of going helter and skelter over the whole broad field of psychiatric care and the likes of this, that he get down to basic facts and tell the House what actually he is doing in this particular field -- and he hasn't done it. And I suggest again to him, Mr. Chairman, while it may be interesting to hear what has happened here in the Province of Manitoba insofar as elderly citizen housing, of course here in the Province of Manitoba there could be only one direction to go, and that was up; because from nothing you must go up -- and when I say "nothing" I recall the type of government that we had here prior to 1958. So there's only one direction you can go, but I want to say to my honourable friend the Minister of Health, you've only taken the teeny weeny baby steps that are necessary in this vast field. Cover the waterfront in your rebuttal if you will, my friend, but let's have basic facts of actually what you've done, and you haven't established that here tonight.

MR. LEMUEL HARRIS (Logan): Mr. Chairman, the other day I received with the rest of the members of the Legislature, the Manitoba Department of Labour, the Bill for '62. This deals with the many facets of health care in Manitoba. According to this review we have a very vigorous Minister of Health who is trying to do a good job under adverse circumstances. One thing is clear throughout the whole scheme. Although all branches of health activities are covered in a piecemeal fashion by the Manitoba Department of Health, no one individual in the province receives full medical attention at all times under this form of administration. In order to have a healthy populace it is necessary that our people in all walks of life should have the benefits of a comprehensive medical plan that would take care of all their health needs at a minimum cost to all. Under the present system of private medical insurance a sick man can go to his doctor for diagnosis and treatment and obtain this under the private medical scheme. However, if the man does not have the money to buy the drugs prescribed for treatment by his doctor, then the medical insurance is useless to him. He will not be able to obtain the necessary treatment, and he will not get well. If a truly comprehensive medical plan were in effect the drugs would be supplied to the patient, and a logical cycle of diagnosis treatment could then take place. Private medical plans do not cover many services that are necessary for the treatment of the sick. For instance, ambulances must be paid for by the patient. Presumably, if he does not have the money, he must take his chance at home or die because he happens to be a citizen of a province which is backward in providing the proper health scheme. One of the best parts of a comprehensive medical scheme is that a man after a serious illness is able to fully recover in a convalescent home, with all his financial worries taken care of until he is able to work again.

On Friday evening, the Minister of Health in one of his replies said Manitoba was the first in this, and the first in that. With regard to health, I wonder if he would consider making a comprehensive medical plan another "first" in Manitoba. A comprehensive plan is what you need here. I have seen people go to work sick, because they couldn't afford to go to a doctor; they couldn't afford drugs. That person goes in there and becomes a drag on the community, because we haven't nothing here that can take that man and make him a healthy citizen. In other

(Mr. Harris cont'd) .....parts of the world -- in Great Britain I know for a fact that these people are healthier today because they have a comprehensive scheme that looks after these people all the way through. And it comes back, it comes back to the country itself, because you have a populace that is healthy. We here, the average man, pays up to $200.00 a year -- $200.00 a year -- and what do we get out of it? To the west of us,they pay $48.00 a year. Right in Saskatchewan, if you want to know where it's at!

A MEMBER: You tell us, Harris.

MR. HARRIS: We're not here to tell you. No, we have no doctors because you — you people drive them away. Yes. You people drive them away. --(Interjection) -- No, that's for sure we don't need our undertakers.

A MEMBER: They chased Tommy Douglas out.

MR. HARRIS: Yeah, they chased Tommy Douglas --huh, he can look after himself! I'd like to see you arguing with him! He'd tear you all limb from limb. And in conclusion, the New Democratic Party makes no apology for its constant endeavours to bring about the comprehensive medical care plan for all citizens. We'll not cease in our efforts until this desirable objective has been accomplished.

MR. WRIGHT: Mr. Chairman, I want to say a few words. I had intended to wait for the various items, but I think I should, because my remarks are general, I should say a few words here. I would like to start off, Mr. Chairman, on the keynote of appreciation. I think it was Maurice Fletcher that said that the word "appreciation" should be nailed over every door. I think that if we didn't appreciate the work that has gone on before us, we wouldn't be able to set our sights probably far into the future.

Reading the Premier's submission to the Commission on Health Services, I was interested to find out that until 1928 the responsibility for health in this province rested with the Department of Agriculture — I believe they called it the Department of Agriculture,of Statistics and Health, and it wasn't until 1928 that a Department of Health was established. And I well remember I was elected to the council in West Kildonan in the fall of '45, and I remember the first health units that were set up, and we were mighty proud of them. We were mighty proud of the Kildonan-St.Paul health unit, and I read that in 1961 the province is now served by 14 units. These units are responsible for 75 percent of the population in Manitoba. Now in Manitoba, as you are aware, we have two schemes. We have the compulsory scheme of hospitalization, the Manitoba Hospital Services Plan, where a man with a family pays $4.00 per month, and he can also subscribe to the MMS or some other private scheme, and the same man with a family would be paying $11.35 per month for this protection. Mr. Chairman, this is a total of $184.00 per year for coverage, and I submit that this is not comprehensive care at all. And while we're talking about the Social Allowances Act, this is only health insurance for the indigent. I want to emphasize that. This doesn't take care of the fellow who happens to be getting a minimum wage in Manitoba and raising the kids. Dental care is not included. Physiotherapy -- many people require physiotherapy, and I was glad to hear the Honourable Minister mention the new concept of care which includes physiotherapy. Osteopathy -- if you want to have your eyes tested, you can have them tested under your Manitoba Medical Service Plan, but you can't get the services of an optometrist. And who knows, there may be times when we need even the services of a chiropractor. Drugs, as I pointed out in my speech -- Speech in Reply -- for the first time in the United States the cost of drugs exceeded the cost of medical care. This is the first time in history that this has happened. I have no reason to believe that this isn't the case in Canada. Ambulance service, too, is something that's not included, so I submit that these private plans do not give proper protection.

I would like to read briefly from the submission by the government to the Royal Commission on Health Services. It says, and there seems to be a little inconsistency here, at least that is in my opinion. Section 9 on page 4 the Premier said and I quote: "In your statement at the opening of these hearings in Ottawa, Mr. Chairman, you stated as follows: 'The view appears to be developing, taken into account increasingly by governments, that opportunity for good health is a right possessed by all and should become available in one form or another to every citizen of Canada.'" But then in the next paragraph I'm a little confused because he went on again: "Your words, Mr. Chairman, represent the philosophical approach of the government of this province to the problem of health and medical services for our citizens. It is important

(Mr. Wright cont'd) ..... in defining any philosophical approach to keep in mind the proper role of government.It is our view that governments should be aware of the fact that it is the individual who has a right and the responsibility to provide for his needs. It is the government's function to assist when the individual is unable to care for himself, and to take full governmental responsibility only in those areas such as the control of epidemic diseases, in which the state itself has a prior interest."

This brings to mind, Mr. Chairman, the plan of the former Liberal government, for they did just that. But you had to be in hospital, if I remember right, 180 days before you were entitled to this help. The proper role of government certainly is to provide for the indigent, but what about the 350,000 people of Manitoba who have no coverage outside of the Manitoba Hospital Services Plan? Not to mention many of the 525,000 people who have already subscribed to the MMS and other private plans, and who are finding it very difficult to keep up with the ever-increasing costs of premiums. I quoted in my speech last week the case of an 80 year old lady who's sole income is $65.00 per month, but because she is living with relatives who are good to her she is able to get along. Out of the $65.00 per month, she sees her way clear to pay into MMS -- $14.35, I believe, per quarter. Yet the very things that she needs are drugs. This she is denied under MMS. Now, if this lady were to become indigent -- and I submit that on $65.00 a month, even though she is living with relatives, she can't be very far from that -- I submit that there must be something better than the plan offered by MMS which denies this lady at 80 years of age with the sole income of $65.00 per month and she has to buy rather expensive drugs.

So there are inadequacies, glaring inadequacies in the present coverage for people. Now I know we have imperfections. None of us are perfect. We're living in an imperfect world.But we have made progress, and have made great progress in medical service. I think that we have in Manitoba here some of the most dedicated people in North America. No one would want to turn back the hand of time. I don't think any one of us would want to go back to the days of the revered general practitioner, who not only was the obstetrician, the pediatrician, he was the family councillor and, if there is such a word, I believe he was even the geriatrician. The point is that he had to wait for his money, too. Some of these ..... of Manitoba, we had dedicated people who served the community and never received the money that they were entitled to. This is what I mean by dedication. But none of us would want to go back to that. And I want to point out, Mr. Chairman, that there has been a great gain for the doctors too because of this. Because these insurance plans are, in my opinion, mainly real good insurance for the doctors. And doctors today are just as dedicated, even though they work in a more impersonal, sterile and oftentimes sophisticated atmosphere of specialization.

The Honourable Minister was using the word "concept", and I believe him. I think that the government has taken a new idea of the concept of prevention, certainly a new concept of care in our psychiatric institutions. We've come to the point now when we realize that it takes more than confining people into an institution and putting them out in the fields into farm work. It requires a far greater ratio of psychiatrists today than we did before because of this new concept, and I also think that we are coming to the point of view where we are beginning to take the attitude that we must get something better for our low-income groups than social allowances, and I'm not trying to belittle social allowances. It certainly is filling the need for people who are indigent but it does not fill the need of the people in the low income groups. So I say, Mr. Chairman, that medicare, for want of a better word, must come. It's inevitable that it must come, and I would close by saying that I think that we aren't that far behind in Manitoba with all our criticism of this government. I think that we will see with the new concept that we are getting to the care of the elderly and that, I think that with a little prodding and we of this group have long realized that these things cost money -- we don't have to be told that -- but I don't think there are better places to spend money than for education and for health.

I think that's all I want to say, Mr. Chairman, at the present time. I'd like to say something under the various items.

MR. CHAIRMAN: Item 1(a) -- Passed; (b) -- Passed; (c) -- Passed.

MR. MOLGAT: I believe the Minister was going to get up and make a statement here on (a).

MR. JOHNSON: Mr. Chairman, I don't want to hold up my estimates by any means, but probably I wasn't too articulate in trying to cover the several points and the Leader of the NDP Party brought up a question ... it's such a big subject and I'm probably too close to it to give the kind of objective view that the committee should have. However, I'll try once more.

I want to point out to my honourable friend -- (Interjection) -- no, with all respect to the Leader of the NDP Party, but I'm one of those, I just can't let a blatant statement go by completely unchallenged such as he made here.

The so-called division, as I was trying to point out, in the provision of care services -- and I always appreciate my honourable friend from Seven Oaks because he's a builder; he believes you go from baby steps and big steps and you build on what you have in the Province of Manitoba, and we are building on what we have and we've made some giant strides. Whether the Leader of the NDP believes it or not, the people of Manitoba, I think, believe it by and large. When he says we're just making baby steps in these areas, I was trying to point out in my remarks the other evening, I think we are making some real large strides, and first. And in tackling the several areas -- and I use the word "extended care" described by some as the so-called " grey" area -- it's an unfortunate term but it's used by the people in the care field to the so-called experts in defining the several elements and kinds of medical care problems that fall into little category -- we try to, there seems to be a tendency to over-classify this group of people and their needs, and it is difficult, with all respect I'd say to the Honourable Leader of the NDP Party, to combine. We need a combination of health and welfare skills in this particular area because we run into such a diversity of problems. When a patient is acutely ill, there's no problem or question of where he should be placed, or whether, when he needs extended treatment, or when he needs just housing or hostel accommodation -- he's up and about and able to come to meals; he doesn't need much medical care, possibly periodic visits by a physician; but when you come to the extended care area, the emphasis, as I was trying to point out, has been placed on the rehabilitation concept by using the skills of our excellent doctors who are knowledgeable in chronic care and rehabilitation, to use this to the maximum force in the Province of Manitoba. And with the development of our day hospital concept, the municipal hospitals and the progressive care unit that the staff in that hospital have developed, with the Rehabilitation Hospital and so on, we have attracted the officials of the Saskatchewan health services to our province to look at these progressive measures. And I would say, with all respect -- and I give the Leader of the NDP his credit -- they've, Saskatchewan, developed a geriatric centre in Regina. I've been to it, across from the Parliament Buildings -- very excellent facilities -- and they are concerned as we are concerned that these kind of facilities without a concept of active rehabilitation and so on can become just so-called "lie down facilities". We've got to have these concepts before us all the time and never give up in trying to maintain the patient in his own home if he's happier there, in a proper housing unit, trying to avoid the long-term institutional care where we can.

Let me say another thing to the honourable member. In these estimates you see the care services division. We have found after four years that we need these health and welfare skills, and we have made the attempt with the commission, in consultation with the hospital people and the City of Winnipeg Health Department and ourselves, to set up this care services division which will have not only the nursing skills and medical skills, but the welfare skills where the aged and infirm division of the welfare staff are in constant touch, constant touch and working with the physicians in the department in a placement service so that we can help people to obtain the proper accommodation. Working in vacuums we can get duplication and poor placement. We're trying to avoid this insofar as the several responsibilities of our own are concerned, and to be perfectly frank with the Honourable Leader of the NDP Party, to have Radisson ..... to ..... come down from above ..... the hospital plan in examing this area with the care services division, and considerable progress has been made in getting this concept under way. I just wanted to make that point to the honourable member.

I didn't know that we were getting into the whole question of comprehensive medical care. I don't know if this is the place or in the Minister of Welfare's estimates, but I think for the

(Mr. Johnson, cont'd) ..... advice of the committee, I think we must always remember that we in the Province of Manitoba have come a long way in the provision of comprehensive care services, and we tend to use the word a little loosely at times. Comprehensiveness means all kinds of medical plans, and when you examine it, you must realize that today the care of the mentally ill, tuberculosis, so many of the essential public health services, are all under the auspices of government -- the provision of medical care to people in nursing homes, and now the beginning of Medicare and looking after those in receipt of social allowances; the development with substantial monies of the out-patient department of our teaching hospitals. These are all major steps -- the development of all cancer treatment services other than medicine and surgery; the gradual development of laboratory and X-ray services. We are gradually building a firm kind of comprehensive care scheme that is Manitoba's scheme, and I think the Honourable Member from Seven Oaks hit the nail on the head. We continue to build on that which we have, on that which those who went before us have developed, and to break out in these areas from year to year in new concepts, taking advantage of the new concepts of care and latest advances in medical science, but always keeping that happy balance and not letting one particular area fall too far behind as we advance forward all the way from cancer services, treatment services, mental health and public health services; public education, and all these several matters which make the Department of Health such a long-winded department but such an exciting one.

MR. PAULLEY: Mr. Chairman, I was very interested in hearing the last remarks of the Honourable the Minister of Health. I appreciate very much that what he has said more or less substantiated the remarks that I made a little earlier, because from the remarks my honourable friend does indicate that he is in complete agreement with me, that he is only following what somebody else has started before. Where? In the field of cancer treatment. Now we're often criticized, we of the New Democratic Party in this House, because of the fact that we make reference to the government of the province to the west of us, and certainly in the program of cancer treatment there in the province to the west of us, they weren't followers; they were leaders for years. Since the CCF New Democratic Party became the government of the Province of Saskatchewan there has been provided for all of the citizens of the Province of Saskatchewan free cancer treatment.

My honourable friend mentions psychiatric treatment. I think that it is perfectly true that in this field there again that province to the west of us has given leadership in the field of psychiatric treatment; in the breakdown of the old institutional treatment centre that there they have given outstanding leadership, and I appreciate the fact that my honourable friend the Minister of Health, the Member for Gimli, is in this field also following what has been done in the province to the west of us, and I appreciate, and I want my honourable friend not to be too hard on me, because I appreciate what he is attempting to do, the steps that he is taking, here in the Province of Manitoba to catch up, and I appreciate the troubles and the trials and the tribulations of my honourable friend in trying to convince his colleagues on the treasury benches in the Province of Manitoba how vitally important it is to start making some progress in this field. And I wish him every success. As I said on Friday evening, I hope my honourable friend the Minister of Health -- and I think that he believes in the same things that I believe in only he daren't say it in this House -- I wish my honourable friend every success. As he stood up here the other day, on Friday evening, and said how glad he was that here in the Province of Manitoba we were able to go ahead with a system of hospitalization, I said to him that I hope, I sincerely hope that two years hence in the year 1965 -- and as I said I presume that we won't have an election before then -- that I hope that in the two years between now and 1965 my honourable friend with all of his vigour and all of his vitality and persuasive powers will be able to convince the First Minister and the others in the treasury benches of the Conservative Party here in Manitoba, that they should follow the Province of Saskatchewan in Medicare, and I wish him every luck, every success, and if my honourable friend wants some support by giving him information, I'll gladly take another month or two off from my vocation at the CNR and give him every bit of support that I can, and I want him to be able to say in 1965, "Well, Russ, I've achieved what you wanted and what I think is necessary for the people of the Province of Manitoba," because I respect my honourable friend and I sincerely think that he believes exactly the same as I do, only as I said a moment or two, Mr. Chairman, he

(Mr. Paulley, cont'd) ..... daren't put it on the record of Hansard in this year of our Lord, 1963, but he will. And I predict, as the Honourable Member for Gladstone mentioned before we recessed at 5:30, reflecting on the remarks of my honourable friend at a meeting in Elmwood in respect of hospitalization, I'm sure that the Honourable Member for Gimli, the Minister of Health, will be very, very happy at the time of the next election to be able to go into some constituency and say, "We brought about medicare in the Province of Manitoba," so I wish him the very best of luck.

Now then, I still say to my honourable friend however, he's got a lot of convincing to do with his colleagues in the treasury benches here in the Province of Manitoba. I still say that he has a misconception in the field of alternative care, in the field of extended care, in that he's still linking it in with the field of welfare. Even in his remarks just a moment ago he could not help but bring into his rebuttal the association with welfare to extended and alternative care, and I say again to my honourable friend: Away with it. Away with it. It is the right of every individual that's in the Province of Manitoba, irrespective of their financial situation, to receive the benefits of medicine and science and related fields without any connotation of welfare, and, much as I appreciate the endeavours of my honourable friend, until he disassociates himself with the connotation of welfare with health, he's not going to do the job, Mr. Chairman, that I think the honourable gentleman is capable of doing, and I suggest to him once again, that if he wants any guidance, any concrete, comprehensive and intelligent information, that he come down to Room 252 and he will receive it.

MR. FROESE: Mr. Chairman, before we pass this item -- I feel very strongly about this. I wouldn't even allow the item to pass unless we get some further information on the hospital commission. The only statement that we have on the financial aspects of the commission is this one sheet which gives us an estimated and the actual expenditures for the past number of years, and how much they propose using for the current year. Last year we received a report of the estimated requirements and the estimated expenditures, and that estimate showed that they would end up with a surplus of $108,000.00. However, they managed to come up with $1,069,000 in surplus. This year they're budgeting for a deficite of $1,317,000 and there's some money left from previous years, so that in the final end they hope to end up with $224,000 in the kitty, monies that got there from previous years. Now, my concern is, that last year we received a report of the Manitoba Hospital Services Plan on the operations of the year 1961 ending December 31st. In this report, we have an audited statement audited by George D. Iliffe, and it contains the balance sheet. It shows that there were assets of $12½ million. I would like to know from the Minister what happened to these assets. Were they transferred to the commission and are they still there? Have they grown, or have they gone down; are they reduced? The report also shows a statement of the Hospital Services Fund. We have also a statement of the administrative expenses for the year ending December 31st, of that year, of an amount of $1,348,000 which is itemized. However, this year we have received nothing, and if that is what is supposed to take place by changing from a Hospital Services Plan to a Hospital Commission, I'd say let us get rid of this commission before we lose all control or do not get any report whatever. Certainly this needs an explanation and I certainly would like to get an audited financial statement of both the Hospital Services Plan of last year -- it operated I think till the middle of the year, and from there on the Hospital Commission took over -- and we should have a statement from them on this operation and on the finances of that commission. I begin to think that we should probably engage a firm of consultants to look into this matter, and bring in recommendations of the operation of the commission, also to give advice as to how to retain control of the operation of the commission. It seems to me that we're letting go by the control of this agency which is now a Crown agency, and I feel that we should have more information, we should have a detailed report on its operation at this session.

MR. MOLGAT: Mr. Chairman, I wonder if the Minister will indicate when he will bring in the report of the Hospital Services Commission, because it is true that in the past -- this is the '59 report, which is a printed report -- I believe that in the past two years what I've received was an onionskin report, but at least we had one -- then in '61 we were given estimated reports for three years, giving the full details of the Commission, and it's certainly very difficult to discuss the Manitoba Hospital Services Plan without that information, and I

(Mr. Molgat, cont'd) ..... would agree with the member that before that particular item is passed, the House should have the full information.

MR. JOHNSON: Mr. Chairman, in '61, it's true, the annual report was tabled on March 1st, and up to '62 the regulations under the Act made provision for the report to be tabled by the end of February, and then in '62, the Department of Health Act was amended and we permitted the Hospital Commission in that Act to submit the annual report. They didn't have to submit it by March 1st. Now this, as I explained earlier today, is in the hands of the Comptroller and I checked on this on Friday, and I would hope to be able to distribute at least an onionskin tomorrow when we meet. Unfortunately it is delayed this year and it's partly -- I didn't recognize the fact that I didn't have to table it till the end of March, until the estimates were under way, and the chairman of the Commission told me the annual report was ready but for the audited statement from Mr. Iliffe and that should be ready, and I hope I can table it at noon tomorrow.

MR. MOLGAT: I thank the Minister for his statement, Mr. Chairman. Presumably we'll still be able to discuss this under Hospital Services anyway, further on in estimates. Presumably we won't be there until tomorrow.

I wonder if the Minister could advise the committee the status at the moment, and he knows it, of the Federal Royal Commission on Health Services to which he made a presentation last year. Has he any indication as to when this commission will report and when we may expect their recommendations? I note that in the fall -- and this is an article from the Tribune on the 18th of October, "The chairman of the Royal Commission on Health Services has intimated Wednesday that he has strong doubts whether a medical care insurance plan deserves top priority in the mapping of an overall health program for Canadians. The chairman, Chief Justice Emmett Hall, of Saskatchewan suggested that perhaps areas in which progress has notably lagged should be of first concern. He mentioned mental health care, rehabilitation services, and the care of retarded children." I wonder if the Minister could advise the committee as to the position the Government of Manitoba has in this regard and whether he has any news from the federal reports as to when we may expect it.

MR. JOHNSON: I have no idea just when the Royal Commission on Health will be reporting. Probably like many members of the committee, I've heard that June is their target date of this year, but that's all I've heard and .....

MR. PAULLEY: Mr. Chairman, I wonder if the Honourable the Leader of the Liberal Party might tell us what the present position of the Liberal Party is in respect to health care. It's changed so frequently in recent years I wonder what it is. I'm not conversant with it, because I haven't received a comic book.

MR. CHAIRMAN: ..... (b) -- passed.

MR. MOLGAT: Mr. Chairman, no. I believe there are some important matters to be discussed, in spite of the comments of my colleague, the Member for Radisson.

MR. PAULLEY: Not colleague.

MR. MOLGAT: Well, we happen to be sitting on the same side of the House. I will admit that's a purely temporary position for us. You'll be here for a long time yet .....

MR. PAULLEY: ..... Mr. Chairman, but not as a colleague.

MR. MOLGAT: No, I will admit that if you want to take the term "colleague" from the standpoint of the support that you give, you're obviously colleagues of my friend opposite, and this is the way I would like to have you remain. I assure you that you're .....

MR. PAULLEY: I prefer it that way too, Mr. Chairman.

MR. MOLGAT: Your assistance could only be considered the kiss of death as far as we are concerned.

MR. PAULLEY: It hasn't materialized.

MR. MOLGAT: Mr. Chairman, I wonder if the Minister would care to comment on these remarks of the chairman of the Royal Commission on Health Services, whether this accords with his views or not?

MR. ROBLIN: My honourable friend knows that that question is not likely to be answered for the simple reason that it's not appropriate for my honourable friend to make comments of that sort, on what a chairman of the Royal Commission is saying. If he's referring to policy of the present government, naturally we'll make comments upon it, but we will not

(Mr. Roblin, cont'd) ..... make any comments with respect to our own policy until we're in a position to announce it.

MR. MOLGAT: I thank the First Minister for answering for the Minister of Health. He always doubles in on certain portfolios. I think the question is a fair one, whether the Minister of Health of this province is in agreement with this statement or not.

MR. JOHNSON: I'll be glad to answer that, Mr. Chairman. My statement is in the Royal Commission on Health brief of this province, very firm and clear. We believe that mental health and physical illness should not be differentiated, and have made a strong plea for this particular phase of operations, plus several other recommendations.

MR. SHOEMAKER: Mr. Chairman, ... did you want to pursue this, Gil?

MR. MOLGAT: No, it's on another subject that I want to check, Mr. Chairman. It's also with regard to some medical developments in the Province of Manitoba. Apparently there was a request by the Manitoba Medical Association and the University of Manitoba Medical School to establish in the Province of Manitoba an Institute of Occupational Medicine, and the news report, again from the month of October, was that a request for a federal-provincial grant had been filed the year before, but that, as a result of the austerity program, this was not likely to be acted upon. I wonder if the Minister could report to the House whether this will proceed or not? This was to be a joint, as I understand it, federal and provincial grant.

MR. JOHNSON: I'll be glad to look into the matter. I'm not aware of this particular request.

MR. SHOEMAKER: Mr. Chairman, I would just like to ask two or three questions here, and my honourable friend doesn't need to reply until we get down to alternative care if he prefers it that way, but I wonder, in light of the number of hostels that have been built to date, if he could tell us the approximate per bed cost of the hostel type of accommodation -- that's Number 1. And what the provincial and/or federal contribution to the construction of same is, and what the federal and provincial grant presently is for hospital construction, in light of the fact that the hospital beds do cost nearly twenty thousand today. And Number 3, are there any changes at all in the Central Mortgage and Housing attitude as respects loans to hostel type construction? The other one is more of a comment and I would appreciate the Honourable Minister's comment on it. Does he not agree that, as regards alternative care facilities and in particular the hostel type of care -- does he not agree that it is advantageous and desirable to have them localized in the local areas of the province. For instance, I think that Neepawa is large enough to support some alternative care facilities of one kind or another, and I know that the patients prefer to remain close to home rather than have them removed to Brandon, Winnipeg or so on. And another question, Mr. Chairman. On what point in the Estimates would we discuss lagoons and sewage disposal? Does that come under this Department? At what stage in the proceedings do we arrive at that?

MR. JOHNSON: Mr. Chairman, lagoons come under Environmental Sanitation. The elderly persons' housing program is under the Minister of Welfare, and I wondered if the honourable member would like the Minister to take the questions he has asked tonight under advisement and give that report as to the average cost of hostels, etcetera, and the CMHC policy which only extends to housing and to hostels built on a one-for-one basis, and any other comments concerning this program.

MR. SHOEMAKER: ..... the grants as regards hospital construction would come under this Department, would they not? Can you tell us what the provincial-federal grants are for hospital beds at the moment?

MR. JOHNSON: Two thousand dollars provincial, matching two thousand federal.

MR. SHOEMAKER: The total contribution then is $4,000 for approximately a $20,000 bed, and I was under the impression that it was about 80 percent of the cost.

MR. JOHNSON: Mr. Chairman, I have mentioned this I don't know how many times. -- (Interjection) -- Oh no, every year since '58. I'm getting to be schizophrenic thinking of this problem. With all respect to my honourable friend from Neepawa, the formula is quite clear and has been enunciated quite a few times, and I'll give it to you at this time. The federal-provincial grants were raised from $1,500 to $2,000 per bed two years ago. They used to be $1,500.00. In addition to this -- and this is one of the points we made in our Royal Commision brief if you will recall -- when the Hospital Plan came into being we had to devise

(Mr. Johnson, cont'd) ..... a capital formula for hospitals. We wanted them to retain their self-autonomy but we realized as a government we had to go a long way with the voluntary hospital boards under this universal scheme in meeting their capital costs with them in the future, and Manitoba has the most generous formula, incidentally, in Canada, in that we suggested to the hospitals the "20 percent formula", as we call it, and if a hospital were to be built that cost, say $100,000, the local people are asked to put up 20 percent of the $100,000 which is $20,000.00. They then receive matching grants, federal and provincial, provided the plans are approved here and by the architect in Ottawa -- the chief architect for the hospital division of the Federal Government. And then in the payment, we give them depreciation payments through the Commission for everything below grants. That is, other than what we give them outright we give them depreciation on; and then we give them interest payments down to their 20 percent local equity; so if a community is building a hospital for $100,000 and their grants total $40,000, they would float a debenture issue for $60,000 but we would pay the depreciation of the $60,000 and interest down to the $20,000 local equity, and we pay that into a trustee arrangement which we set up by legislation at the last Session. Remember, we made a trustee arrangement much like the school division plan, which permits them -- we pay these monies directly into these areas, so really there is this 80 percent formula which ..... I think that will explain it to you.

MR. MOLGAT: Mr. Chairman, in his original comments the Minister indicated that in 1948 there were approximately four beds per thousand in Manitoba hospitals. The present figure he gives is seven beds per thousand. I wonder if he could give us the year by year development in the intervening period. I realize he may not have the information now and I'm quite content to wait for it till we reach Hospital Services directly in Estimates. I just want him to know this now.

MR. JOHNSON: Well, would you want it year ..... I don't know what figures I can get but -- it was around 4 beds per 1,000 in '48; around 5.7 in '57; 6.2 in '58; but I will qualify these and bring it in.

MR. MOLGAT: ..... as far as I'm concerned, Mr. Chairman.

MR. GRAY: Mr. Chairman, under (b) the Estimates are $84,000.00. In the Public Accounts, which is a year old, I see they only spent about $4,000 on books. How did they spend the other money and what are they actually doing under the health education?

MR. JOHNSON: Well, health education is concerned with the working with the various private and voluntary associations in the province, everything from the Canadian Diabetic Association, the Family Bureau, Middlechurch Home, Boy Scouts -- I have a list here of a whole page of agencies with whom the bureau worked in the past year in the development of health education material, and the past year heralded the establishment of ten poison control centres throughout the province at key points, along the lines of the very successful poison control centre at the Children's Hospital. This was done through our Health Division, through the directors, officials of the Children's Hospital and so on, and the Health Education Department played their role there. The polio immunization program -- and I should mention at this point that when we carried out our polio program last year we had the very wonderful voluntary cooperation and support of radio, press and TV as part -- this was carried out through the Department of Health Education. They made the program as successful as it was with probably the finest program in Canada. Teacher training, farm and home safety, and VD control are some of the projects which were worked on in the past year. Nutrition; several conferences with teachers. Refresher courses for cooks and operators of senior citizens' homes and hostels and nursing homes were held, one at Brandon and one in Winnipeg. A survey of food habits of certain areas in the province and a nutritional consultant service. This is the kind of activity that the Department is directing. Of course we have the film centre and last year 6,000 films were shown. 276,000 people saw these films in Manitoba last year, and there were 3,475 people spoke when these films were shown throughout the province; and film strips; and we distributed about 501,000 pamphlets on various aspects of health education; prepared 102 radio programs and news releases and television efforts and so on. These are the activities of the -- just gives you some idea of the varied activities of the Department of Health Education, and they have the Health and Welfare library close by over there, but this is the kind of activity they engage in.

MR. GRAY: Can all this program be carried out for $83,000.00?

MR. JOHNSON: Yes.

MR. GRAY: Wonderful.

MR. JOHNSON: Efficiency plus.

MR. CHAIRMAN: (b) -- passed; (c) -- passed; (d) -- passed. Resolution 54 -- passed.

MR. DESJARDINS: On (d), the Rehabilitation Program; I'd like to know if the Minister can tell us on this if the co-ordinator of rehabilitation services, is this working with the Compensation Board or have they their own? I think that this is an important subject. I have a lot of people that ask me some information on this. It seems that sometimes they feel that the Compensation Board is pretty strict. As soon as they're finished with the people well that's it, and they certainly -- I imagine that this is where they need the service of this rehabilitation more than anything else. I wonder if the Minister can give us some little bit of information on this?

MR. JOHNSON: Yes, that's a good question. The provincial co-ordinator, the Director of Rehabilitation as we know him now, he is concerned with co-ordinating the rehabilitation services in the community and using the five major rehabilitation agencies which are the Compensation Board; the Society for Crippled Children and Adults, Canadian Arthritis and Rheumatism Society, the Blind Institute, and so on. The idea is to get a patient-centred program; and his job is largely that of co-ordination, and when a person applies or comes to the attention of any one of these agencies and, for instance, needs some service that that specific agency doesn't give that specific service for, the co-ordinator and these agencies have set up a system of dealing with each one of the several kinds of cases. I should point out in that appropriation which is changed from last year, the reason for this was the utilization of the technical vocational training agreement which I mentioned on Friday night, which we're so anxious to make the maximum use of in the coming year, in both the placement of mentally ill and in enhancing and increasing the scope of our industrial workshop for the handicapped operated by the Society for Crippled Children and Adults. Incidentally, the appropriation is up over last year, a total of, a net increase by the province -- expenditures last year were $130,860 provincial and this year are $274,601 provincial. Our total program this year was $322,466 in '62; it's now $520,000 this year. And the major areas of increase have been to the Industrial Workshop and the Society for Crippled Children, Canadian Arthritis and Rheumatism Society, and a special class for cerebral palsy mentally retarded children. But the committee should realize that the co-ordinator's job is to take the statutes and the programs and develop with these five major agencies the comprehensive rehabilitation program which we have.

MR. GRAY: Can the Minister tell me if it's possible what is the total amount spent a year, including the contribution of the agencies, towards this item.

MR. JOHNSON: The total amount, including that spent by the agencies? I don't think I have that right at my -- well, we're spending in these estimates here $520,000 and then the Society for Crippled Children and Adults raised through the March of Dimes and the Easter Seals and so on, I think it's close to $300,000.00. And then, of course, the money spent by the agencies, the other agencies I've mentioned, is not in here. I think that would be about the major item of the money raised by the chief rehabilitation agency here, the Society for Crippled Children and Adults.

MR. PAULLEY: In connection with this department I've had a number of inquiries directed toward me in connection with speech therapists. I also note that in the report of the department, on page 16 I believe it is, listing the developments, item No. 3; "A brief recommending the establishment of a school of speech has been submitted to the Government of Manitoba by the Manitoba Speech and Hearing Association. This brief is now under active consideration." I believe that in this sphere of rehabilitation or development that there is a considerable amount of apprehension of people who unfortunately have children whose speech is retarded, and I wonder if the Minister could tell the committee what is being done in this particular field in order to provide speech therapists. Where may a parent or parents turn in order to obtain guidance in this very important field? Now I understand, and I may not have the story quite correctly, but I understand that there was one speech therapist more or less attached to the retarded children's institution -- I'm not sure if this is correct or not -- but because of the more attractive salary, and there's no criticism of this, had gone into another department

(Mr. Paulley, cont'd) ..... or another section of the department; and I would like to hear from the Minister what his plans are, if any, for the provision of speech therapists and where services may be available to parents who happen to have children requiring these services.

MR. JOHNSON: Mr. Chairman, this is a pretty broad question, and hard for me to answer, but I can only relate the developments in the past while. The acquiring of speech and hearing therapists has become a very real problem. Traditionally, there have been in the past, a speech therapist or two at the Children's Hospital, and she has now moved over to the Rehabilitation Hospital. They are, I think, without a speech therapist at the moment at the Children's Hospital. We have written to every agency some time ago suggesting that bursaries, federal-provincial bursaries were available for anyone interested in taking speech therapy, with, I believe, no response. Only one candidate is on course now under this bursary arrangement, and she's destined to join the Society for Crippled Children at this pre-school centre for the handicapped this year. The Speech and Hearing Association submitted a joint brief to myself and the Minister of Education, and we have been just in the process of looking at this brief which suggests the establishment possibly of a school. This brief was circulated not only to ourselves but to every other university in western Canada, all of whom related the same experience as we were having, namely the lack of candidates and the lack of such personnel, and all expressing interest in this brief. I believe the Minister of Education and myself intend to meet with this group in the near future. In the meantime, having received all this information from the other western provinces, I can't predict just what will happen here.

The Rehabilitation Hospital is also interested in developing more skills in this field in that facility. Also, we'll need these people in our school for the handicapped which incidentally is a -- we should always mention the Kinsmen Club put up quite a bit in this area, in the development of this facility; but we are short. We've been chronically short for years. We have difficulty getting these people. We have a couple in the employ of the Department of Health and Welfare, and of course there are some at the Child Guidance Clinic. But there is a chronic shortage, and not only in Manitoba, but across Canada, and we are looking into it. It isn't something that has just developed overnight, in other words. It's been a long drawn out thing, and increases in salary don't seem to be the whole answer. The whole answer seems to be the acquisition of personnel and possibly one of the western provinces developing a teaching centre for this purpose -- a university course. They now all have to go away down, I believe, to the United States as far as I know. In the meantime, we have had a request from an individual interested mother, interested in this field, concerning the setting up in the meantime of some voluntary assistance and effort in this regard, and I have asked the department to pursue this matter, both the Director of Health and the Deputy Minister, and the Director of Rehabilitation Services. But the hospitals are not able to acquire them, and we have -- I just haven't got the figures right under my fingertips, but the Child Guidance have some speech therapists. We have one in our centre at the Brandon Hospital, the Child Guidance Clinic there, but this is a most difficult problem.

MR. PAULLEY: Mr. Chairman, the remark of the Honourable the Minister. May I first of all say to him I hope that dollars and cents will not prevent him hiring, or his department hiring somebody who is qualified in this particular field of endeavour. I think we all appreciate and realize the handicaps that a child who is deficient in speech has. It might be as well if some of us in here weren't so much the other way. But apart from that, I have had a few parents draw this to my attention. I appreciate the fact, as the Minister has said, that this is a situation that is not peculiar just to the Province of Manitoba, but it's also the concern of others as well, and I ask him, as I know he will, to do all within his power to see that the children who unfortunately are afflicted with speech deficiency have adequate training.

Now I do understand that there is a limited number who have qualified in this field of endeavour. It's my understanding that some have transferred from one department to the other in the field of this endeavour, and as a net result, it seems to me that in particular with the pre-school child that the accommodation of a practical teacher is being most felt, because I'm sure the Minister would agree with me that in this particular field the pre-school child is at a distinct disadvantage, particularly as they arrive at the age of going to school; and again in this whole field, whether it's retardation because of inability to speak, or other mental, physical or functional deficiencies, that all too often in the past, we have considered, particularly in the

(Mr. Paulley, cont'd) ..... field of education, when these youngsters reach the school entrance age at Grade 6, that in the past we have considered them as being retarded children, where the deficiency actually is not one of normal retardation at all, by physical. And I implore the Minister to continue his endeavours, to advertise across the whole of the North American continent and, if necessary, -- I don't know how my honourable friend from St. Boniface what he will think of this -- but even in the United Kingdom, to have individuals come here who are able to fill the vacancies which we have in this very important job of rehabilitation. It's not so much rehabilitation, Mr. Chairman, I would suggest, but to give these unfortunate youngsters an opportunity of establishing themselves in their proper place as useful youngsters in the province, and I ask the Minister to not overlook the fact -- and I'm sure that he won't -- the concern of the parents in the Province of Manitoba who have children who are afflicted with deficiencies in the field of speech.

MR. T. P. HILLHOUSE, Q. C. (Selkirk): Mr. Chairman, I know some of the difficulties with which the Minister is confronted in obtaining the necessary speech therapists but I was wondering -- and the question is actuated through conversations that I have had with one of the teachers at the Mulvey School, one of the hard of hearing classes -- I was wondering whether or no the Minister had considered in conjunction with the Minister of Education of enlisting the services of some of the Winnipeg school teachers or some of the rural school teachers in making available to them, it's sort of an accellerated course, I think, which they can take in one of the United States universities that lasts for about three months, and they may be sufficiently well-trained to fill the gap until you are able to recruit the necessary personnel among fully qualified speech therapists. Now I know that one of those teachers at the Mulvey School is doing a tremendous job in teaching the hard of hearing children. She is not a university graduate, but she did take a course, one of these accelerated courses at one of these American universities -- I just forget the name of the university -- but she informs me that there is a course there which lasts about three months. She also tells me that any good teacher, any good grade-school teacher who is dedicated to her work, can acquire sufficient knowledge of the principles of speech therapy in that course in order to assist the children, both of the school age and the pre-school age, and I realize, Mr. Chairman, the great need we have for speech therapists today, and I don't think we should leave unturned any stone in recruiting the necessary numbers to fill that gap.

MR. JOHNSON: ..... as we think with some, a few highly trained people in a large number of personnel such as this, we can cut the mustard a little bit, but we have the bursary offer there, too.

MR. HILLHOUSE: Mr. Chairman ..... known to the teachers in the employ of the Winnipeg School Board, and the teachers in the employ of the Department of Education throughout Manitoba that this bursary was available, I think that you would get more recruits for these bursaries.

MR. DESJARDINS: Mr. Chairman, I would like to reassure the Leader of the NDP that I have no objection if these people can help the poor underprivileged children. They could come from the United Kingdom or Russia for all that matters, as long as they have not lost their license or had their license suspended in their own country, and as long as they don't replace, and displace, the Canadian personnel that can do the same work. I would like to thank the Minister on the information that he gave us on this co-ordinator of rehabilitation. But going back to this, it seems to me that there is something missing in this -- I shouldn't say co-operation, but the work that they are doing with the Compensation Board. I have had to discuss certain things with this co-ordinator and I can say now that he was very, very helpful but it seems that there's two different departments, or actually three different departments, because it seems to me they have to work very closely with the Unemployment Insurance, and I know that this is a -- it comes under the federal, but if somebody gets hurt at work, they come in under the Compensation Board, they're injured, and then they get this help from this co-ordinator, and it seems that as soon as this is done, one department has just washed its hands and this thing is over, and pass it over to another department. I don't know; maybe there's something that I missed in this, but if I give you an example I think the Honourable the Minister will realize what I mean.

I have had a case where a young fellow was injured, hurt his foot, and they tried to help

(Mr. Desjardins, cont'd) ..... him. They did their best, and they gave him a course; let him follow a course -- a barber's course. Now, as soon as he was finished this course he realized that he couldn't do this work. He was standing on his feet too long. And I know that this will happen once in awhile but it seems to happen a little too often. I wonder if it's possible, if there is anything that can be done -- that they can search -- in the kind of work that can be properly done by these people, these handicapped people. And then I wonder is it possible that we get a little more co-operation -- and all the provinces I imagine would want the same thing — that we get more co-operation, maybe a preferred listing from the Unemployment Insurance for some of those people that can do only a certain amount of work, a certain type of work, because of their injuries. Maybe this is not feasible, I don't know; but it seems to me that we should look into that because I've seen quite a few people that are discouraged after being injured at work. They do get help, and as I say this co-ordinator seems to do the best that he can, but it seems to be very, very difficult to find suitable work, and there seems to be a conflict between the co-ordinator in the department and the Unemployment Insurance. It seems that this man can't do certain work so therefore he has a hard time getting a job. I wonder if the Minister feels that we will, we can do a little better in this, to help those poor people. There might not be a great number in Manitoba but I can see those people are very discouraged. Everything is doing fine; they're making certain payments on the house or something, then they're injured, and they will be on compensation for awhile. After all, this is only an insurance. When this runs out, when they see they can't do anything else -- there seems to be something missing. I wonder if the Minister can tell us what we can expect in this.

MR. JOHNSON: This is interesting. The provincial co-ordinator's job is largely in co-ordinating these services and advising the several -- working with, not advising, but working with the several rehabilitation agencies. This was set up in 1953 in this province, and at the meeting in Banff last year the other provinces in Canada said that we in Manitoba had the best co-ordinated program for helping all forms of disabled people that existed in Canada. For example, if it's a workmen's compensation case, it's up to the Workmen's Compensation Board to -- they provide him with the care that is required, the medical care. They're also obligated to help in the rehabilitation measures. For example, the Compensation Board plays a big role in the Rehab Hospital. They were very anxious to see this facility established. They then are committed to help this man in financing a re-training if he's injured and can't go back to his particular occupation he had. There are other resources of the Rehab Hospital. There are the resources of these other agencies to which he can be referred for anything special. The special projects that the co-ordinator ends up handling alone are few now with the co-ordination services we have, but for example in working with the Society for Crippled Children and Adults the Compensation Board would probably refer the case to the Rehab Hospital for a prosthetic appliance which may be supplied by the Society for Crippled Kids and Adults. Whoever is the paying agency is the one that follows it through on a patient-centred program rather than just having these agencies and making the patient run around. The fullest liaison is established between the Industrial Workshop where the more severe cases come for job re-training or assessment of work habits and so on, and the fullest co-operation with the National Employment Service. As a matter of fact, I think in this particular case the honourable member mentions this chap would be followed by the Compensation Board right through to the end, and any time he needs assistance he can call on the co-ordinator to step in. We get into cases where none of these agencies may pick up the case. We may pick it up direct and refer it to one of the several agencies, or use -- it's a dirty word -- a member of the Health Department Welfare, but this may be a case where they need the combined efforts of the welfare, health, industry and commerce or one of the other departments to assist in this placement.

It might be interesting to know that on analysis of 190 adults placed into competitive employment last year, the total earnings of the 190 people were $351,500.000. The annual payment to Income Tax was $21,800.00. The cost of services to the 190 cases was $70,000.00. The estimated savings, if you want to put it that way, besides the human savings, was $42,000.00. I'd like to give an example to the honourable the member. I don't know if this is what he's getting at. This is an example of a lady I know very well. Injured in '53; complete

(Mr. Johnson, cont'd) ..... lesion of the cord and confinement to a wheel chair. Extensive treatment under the auspices of DVA. Given vocational training as a clerk-typist under a federal-provincial vocational training agreement. This is where none of the specific agencies had the case, and on completion of training she obtained employment with a salary of $150.00 a month. Prior to her vocational rehab she was in receipt of full disability allowance. Were it not for her disability she could manage on her income. However, in order to keep working, she required medication at a cost of $20.00 a month, taxi transportation at $30.00 a month. One year ago it became apparent she couldn't continue in her employment unless some way to supplement her income. Now she receives medicare and hospital coverage and these extra costs are met in keeping this girl at employment which she enjoys, and keeping her in the community. This is the number of agencies that are involved.

Another chap, 24, was injured in a car accident. It wasn't a compensation case. He sustained a paralysis and he was trained in self-help with dressing and so on. He can propel his wheel chair and in spite of his severe disability he's up and about, and this involved the Canadian Paraplegic Association, municipal hospitals, the Regional Welfare Office, Health Unit, Town of Flin Flon and the co-ordinator of Health Services. The home-care program was developed for this particular individual, and we maintain regular contact with him in this community. Day after day these cases that tend to fall between the grates, as it were, are picked up and we can re-route through the several agencies and so on we have in the community.

MR. DESJARDINS: Mr. Chairman, ... realize I was a little vague in asking this question, so I'll try to do a little better. I'll read this letter that I have received to the Minister and then maybe he can tell me what he would suggest in this case. I think it will help the members of the House who might have the same kind of a letter. I received this call and I said, "Well, put everything on paper so I'll have the information," and this is what happened. "I was working for Western Asbestos Co. Ltd., 1574 Erin Avenue, Winnipeg." Of course I won't give the name of the person here. "The Unemployment Insurance say that they cannot give any insurance because it has been too long since I have worked and they can't find work for me. The rehabilitation worker for the Workmen's Compensation Board is Mr. so-and-so. I have never signed anything. The date of the accident was December 3rd, 1957 at 4:15 p.m. I fell off a six-foot stepladder and fractured my right hip. I spent nine weeks in traction in the hospital and came home in February and went back in October, 1958, for three weeks for a check on my bladder and kidneys. Early in '59 they put a metal cap in the hip and in October '59 they sent me to take a barber's course at the MTI. After completing the course I worked for approximately three months and found that I could not stand all day. Following this attempt to work I re-entered the hospital October, 1960, at which time the doctors found it advisable to fuse my hip. I spent six months in a cast and again in October, 1961, the hip became infected so they operated again. After six months' convalescence in 1962 they put five screws in the hip and I was again six months in cast. The Workmen's Compensation Board was paying me $50.28 a week from December 3rd, 1957 to December 1st, 1962. Since then they pay me $17.17 a week. During December '62 the Mother's Allowance supplemented the pension from March 1961. This money went to pay for the help my wife requires with her housework. She has a heart condition and is entering the hospital March 17th, 1963, for a major heart operation. My doctor is Dr. so-and-so. I am now wearing a lift on my right shoe of half an inch on the sole and three-quarters of an inch on the heel. I am not receiving any assistance from either the Mother's Allowance or the Welfare because I am supposed to be available to work, but they have been unable to place me as yet. I have four children."

You see, this seems to be a man that's up against it. We talk about suffering and we think that this is forgotten here in Manitoba and this is a case that somebody doesn't know what to do. It seemed complicated. Of course, I tried to get in touch with the Compensation Board and they told me -- which apparently is the only thing -- they had studied his case and you see, they're not too worried -- I shouldn't say they're not worried but it's not their worry to look after his wife and so on, so they say, "Well all we can pay, this is final, you're getting $17.17 a week," and I can understand that, but where does a man like that go and what does he do after this? This seems to be a case that's certainly deserving. I find it very difficult to know what to tell these people, and it seems that I have two or three like this a year. I wonder if by maybe suggesting something for this case the Minister would answer me for my future enquiries.

MR. JOHNSON: Mr. Chairman, this is quite a long story. I imagine — it could be something that -- it shows the need for individual assessment in different cases. This man's problem is with the Compensation Board primarily with respect to his disability, and one would have to get an expert report on that, and if it was referred to me I would suggest that he seek recourse through the Board or get some separate assessment made if he's not satisfied with the assessment which that Board has made. However, I'm just speculating. Secondly, if he feels he has been mismanaged on the social allowances assistance he's been getting, he has the right of appeal to the Department, and if he feels he has been badly handled he has the right of appeal to the Public Welfare Advisory Committee. However, I would suggest that this be -- this is the type of case if it's brought -- and it may have been brought, I'm just speculating -- to the co-ordinator of rehabilitation's attention, he usually gives a full report on it to the Minister concerned and we get these cases periodically brought to our attention.

MR. DESJARDINS: Mr. Chairman, would the Minister say that this would be a good case to bring to the attention of the co-ordinator? I phoned the Compensation and they feel that this is it. Now the man is not complaining. He just doesn't know what to do. He doesn't know where to turn; so if this is the way -- maybe this is a case that should be referred to the co-ordinator who would have the answers more than I would and would know the case.

MR. CHAIRMAN: Resolution 54 -- passed. Item 2, Health Division (a) Psychiatric Service.

MR. GRAY: Mr. Chairman, may I direct two questions to the Honourable Minister. Number one is, can he tell us, if at all possible, the total population in the psychopathic wards, in the mental hospitals and any other institutions that take care of mental disturbances, call it this way. In other words, the item of about $7 million; it's on pages 14 and 15. The second question is, why do the staff, while housed in the institutions, pay for their board? In other words, I believe that ..... like the hospitals. They don't charge for food for the nurses, for the other service people that are in the institutions. I see here a couple of items amounting to quite a bit of money. In one case it's $71,000; in another case it's $50,000; and I cannot see the logic of it because institutions where the staff is housed, I think it's unreasonable to charge them for meals and lodging. They are there for the services that the institutions require.

MR. JOHNSON: On that question I would just say that the first question, the exact number of people -- I have it here somewhere but I -- we have 56 patients at the Psychiatric Institute, and the Brandon facility is in the neighborhood of 1,600; Selkirk is in the neighborhood of 1,000 to 1,050 -- it's down from the 1,250. Remember we had quite a big patient population drop there due to our programs in the last couple of years, and Brandon is down somewhat although I think it's around 1,600 in that facility. If the honourable member wanted precise figures, I think they're somewhere in my annual report here. -- (Interjection) -- Beg pardon?

MR. GRAY: ..... total patients in all the institutions. The total.

MR. JOHNSON: Forty-two hundred in all institutions.

MR. GRAY: Twenty-two hundred.

MR. JOHNSON: Forty-two hundred.

MR. GRAY: Oh, forty-two hundred.

MR. CHAIRMAN: (1) -- passed.

MR. GRAY: Mr. Chairman, ... is the staff being charged with meals and lodging?

MR. JOHNSON: As far as I know, and I've been out to the institutions -- I'll check this particular item. I'll have to get that precise information.

MR. MOLGAT: Mr. Chairman, I'm always very happy to be able to help the Minister. The reply to the first question asked by the Member for Inkster is found on page 18 of the report given to us by the Minister.

On other subjects, this afternoon the Minister handed us, Mr. Chairman, the summary of hospital construction projects as at December 31st, 1962, and then a number of schedules attached to it, and I thank the Minister for this. I would ask, however, if it's possible, when we get these reports from year to year, if they could be made in a comparable form so that we can follow the development, because last year the Minister also had given us -- yes, a somewhat similar form but it's very difficult to relate the projects. Now in last year's list, Mr. Chairman, there are a number of projects which I don't see reported in this year's list. I wonder if the Minister could. I'm referring to page 6 of last year's list. Under the mental hospital

(Mr. Molgat, cont'd) ..... program he has, Portage Home for Mental Defectives, a female residence scheduled for '62-'63, a main building '62-'63 and a male residence '64-'65. It's not included in this year's report. At Selkirk -- the Selkirk Mental Hospital, he has Community Mental Health Centre '62-'63, then other projects of a mental health nature, psychiatric facilities attached to General Hospitals in various locations, and this was to be phased over seven years to begin in '63-'64. Then there was to be a 20-bed children's home in Winnipeg in '64-'65, and a retarded children's day centre in Winnipeg also '64-'65. None of these, as far as I can find them, appear in this year's report, and I wonder if the Minister could give us a report now or provide us later with the information on this.

MR. JOHNSON: Mr. Chairman, with respect to the latter, I think all this will be covered at the time of the Capital Estimates of the Department wherein the mental health votes are accommodated. I can point out to the honourable member all these have gone forward with respect to Portage, plus a vote in the Capital vote this year where the costs of -- as you know all the costs of mental hospitals are a provincial responsibility, and the Selkirk Community Mental Health project should open this fall. We had passed sufficient monies in two previous years for this and tenders were out and accepted and the building is under way. We passed around $750,000 which covered that item.

The psychiatric facilities in various locations -- I think we called in last spring and discussed with the Board of the Winnipeg General Hospital the development of psychiatric facilities in that location as the first step, and the provincial psychiatrist has been involved with the Board over the past year, since the House last rose, in planning these facilities with that hospital. I met with the Board and our psychiatrist and staff have been working with them in planning a facility in that area. I haven't got a further report on that at the moment. I've also been in touch with the children's home planning in this area and we set aside, as you recall, last year sufficient grants to develop something in this field. The retarded children's day centre -- that was the idea of the sheltered workshop where some grants were put aside and that has not proceeded. But these grant monies are set aside and I think I should either tomorrow, or at the time of Capital Estimates with respect to Mental Health projects, make a report on this.

MR. MOLGAT: Mr. Chairman, I wonder if the Minister could give us at the moment some information on what other areas or what other locations he intends to open psychiatric facilities connected to hospitals. His report this year indicates that there are four general hospitals in Winnipeg with approximately 140 psychiatric beds. Is it intended to have these facilities outside the City of Winnipeg as well? This report of his last year, could he indicate to us what general area he intends to cover, what other locations?

MR. JOHNSON: ..... very general terms, Mr. Chairman, in the development of mental health facilities. This is somewhat in a state of flux. The feeling was at the time of drawing up the program that the Honourable Leader refers to, it was contemplated that two or three hundred acute psychiatric beds should be made available in the next few years in the Metro Winnipeg area if we developed the kind of community mental health facility at Selkirk which we are doing now; acute beds in Winnipeg and at some future date possibly a facility in the northern part of the province, but no specific site has been contemplated and I don't think it will be until we get ..... The immediate need is in the Greater Winnipeg area.

MR. GRAY: Mr. Chairman, may I ask a supplementary question? You mentioned something about foster homes of those patients who could be discharged from the mental hospital. Question number one is: What do you intend to pay per month? And secondly, whether they're easy to get.

MR. JOHNSON: I think I made a full report on that. It's either $65.00 or $75.00 a month that is paid to a foster home or person who is keeping one of our patients in their home in a board and room situation. The response was fantastic. The volunteers from Selkirk who did the advertising and sparked the program to start with found a very ready response. It far exceeded their fondest expectations, and I think I outlined to the House the other night, and it's in Hansard, just how they went about doing this. That they did the advertising, contacted possible candidates. These people were then referred to a psychiatrist in charge of the program, the mental hospital who have a social worker visit the patient. The patient was then brought to the hospital and introduced to the foster home parent, introduced to the patient concerned, and the fullest understanding developed before final placement was made, and as I mentioned the other

(Mr. Johnson, cont'd) ..... day, I think 139 of these patients are receiving assistance through utilizing the full resources of the unemployment assistance agreement. These are people who were five to twenty years in the Selkirk facility.

MR. DESJARDINS. Mr. Chairman, I think that it's an accepted fact now that we want to decentralize this care of the mental patient. The Minister spoke of more beds in the City of Winnipeg. My question is this. If I'm right, the hospital care of these people is not covered by the plan, or if they are it's just the province that are paying for it. We do not receive any help from Ottawa. Now where do they draw the line on that? The people that are in the hospitals in the Greater Winnipeg area, does Ottawa, does the Federal Government pay us towards that or where do you draw the line? Some of them might be just in for a nervous breakdown. This is something that is interesting.

MR. JOHNSON: I don't know how far I should go in answering the honourable member's question. We've managed to sneak by -- there's no more than ten percent of our acute general hospital beds, not more than ten percent are psychiatric. We have been managing to get federal sharing on the in-patient services in this case.

MR. DESJARDINS: Ten percent of all the patients or ten percent of those in Greater Winnipeg area?

MR. JOHNSON: Sixty psychiatric beds.

MR. DESJARDINS: Oh, that's including Selkirk and Brandon and all those?

MR. JOHNSON: Oh, no.

MR. DESJARDINS: Oh just the ....

MR. JOHNSON: ..... hospitals that you and I have spoken of.

MR. DESJARDINS: And you're satisfied with this, Mr. Chairman, this percentage?

MR. JOHNSON: Ten percent.

MR. MOLGAT: Mr. Chairman, did I understand the Minister correctly in his reply to me that it is not planned then to extend psychiatric additions to hospitals outside of the Greater Winnipeg area, in other words areas like Dauphin, or The Pas or Flin Flon or those not directly adjacent to the Winnipeg area where these facilities are not available. The Minister does not plan on adding these -- and I am referring now to his statement of last year -- to other hospitals than those that are presently in existence in Winnipeg?

MR. JOHNSON: As we can develop the community mental health concept, Mr. Chairman, we would hope that with the assistance of our community mental health teams who necessarily are based at this time out of our larger hospitals in beginning the program, we would just love to be able to see six beds, for example, set aside in the Dauphin Hospital for the treatment of psychiatric illness, and as long as the physicians in that area have a visiting team of psychiatrists and so on, coming on a regular basis, then we can offer some stability to the program. This is our first step, we hope; this is what we would like to see developed through our community mental health program. And then, as we get a better appreciation of our problems, we can decide further, but I think if we can get the community mental health teams dispersed in this way..... The whole thing depends on staff in the field. If you've got the people you can get the ready understanding of the hospitals that keep going throughout the province, I think, to go along with this concept of treating people the same as we do the physically ill in our acute general hospitals.

MR. DESJARDINS: I think that the Minister said that there was five percent, I believe, more increase -- every year five percent more increase of voluntary admission, and I wonder if he could answer, if he feels that the increase in beds in the Greater Winnipeg area or in the communities would have something to do with this, and if once we have more beds around Dauphin and like the Minister says, the people will accept this as any other disease, that the increase of voluntary admission will go still higher.

MR. JOHNSON: Absolutely, Mr. Chairman. I'm convinced that we can bring mental health back into the community and into our acute hospital system that we'll get a much greater emphasis and much more willingness on the part of individuals to seek psychiatric care earlier just as you've pointed out.

MR. GRAY: Anyone in a foster home which has some trust funds with the custodian, can he get some for his other needs and board and room?

MR. JOHNSON: Would you repeat the question, please?

MR. GRAY: We are placing now those who could be discharged from a mental hospital in foster homes, and I assume that the province pays the $65.00 a month for them. If they have any funds with a custodian can he draw on the other necessities from that fund or is the fund returned to him the moment he enters the foster home?

MR. JOHNSON: I don't think many of these patients have many funds of this nature. I will check on the member's point and report on it later.

MR. CHAIRMAN: (a) (1).

MR. MOLGAT: Coming back again to the Minister's statement on community mental health development, he indicated that apparently there are some difficulties in getting staff, to get these travelling teams. Is that what I understood him to say? What I'm interested in knowing, I agree with the Minister that if we can decentralize this, this is good. If we can get these people closer to their homes I think it is a very desirable project. The Minister has spoken about this in the past. Now, what I want to know is, when is this going to happen? When, for example, is say Dauphin going to have one of these, and who takes the steps? Is it up to the local hospital board to approach the Minister if they wish to do this, or is the initiative in the Minister's hands, or where do we start and then what is going to happen? What are the plans for this development?

MR. JOHNSON: Well actually, we have just started with community mental health in the last three years. We're adding two teams out of the Brandon facility this year in these estimates, which are up from $406,000 in '61 to $908,000 this year. Until we can provide a regular course of visitation I don't think we want to approach the hospital boards, but I think without me approaching them or anyone in -- I think through our Health Unit directors and so on, throughout the province now, these people are met at our health units, many of which are in the hospitals, and I think the community mental health teams are helping physicians treat patients now, especially helping them follow patients on an out-patient basis, just being a right arm for example to the GP, say, in Swan River in helping him keep that patient in the community, and I wouldn't be surprised if they're admitting patients now. We're trying not to make any difference in this. I would have to check and see if they're actually being admitted. In certain areas I know they are, but we're not making anything more out of it. We're just sending out the teams to work through the local doctors and use them in any way they see fit to start with, and following our own case load -- you know that they have gone back to that community from, for example, the Brandon Mental Hospital, but definitely we have planned as we got this going on a more regular basis and .....it up with staff, that the next step was to make a formal approach to the larger hospitals concerned, to the hospitals in these larger centres, for example Swan River, Dauphin, etcetera, to do this. We were a little disappointed, and I'll be frank about this. Last year we got going on a regular basis as far as Swan River with the psychiatric team and became absolutely snowballed with so much work that we found we just couldn't work the staff any harder and we had to apply for a further two teams this year. But as we can develop the personnel and assure regular visitations -- we are already getting the tremendous demand; the response has been magnificent -- I see no difficulty, just a natural consequence that besides supporting them as out-patients that physicians will gradually accept these people as in-patients knowing they have help on a regular basis.

MR. ROBLIN: Mr. Chairman, I was just about to move the committee rise as I suppose there are further points to be raised on this matter. I move the committee rise.

MR. CHAIRMAN: The Committee of Supply has adopted a certain resolution and directed me to report the same and asks leave to sit again.

MR. MARTIN: Madam Speaker, I beg to move, seconded by the Honourable Member for Springfield, that the report of the Committee be received.

Madam Speaker presented the motion and after a voice vote declared the motion carried.

MR. ROBLIN: Madam Speaker, I beg to move, seconded by the Honourable Minister of Health, that the House do now adjourn.

Madam Speaker presented the motion and after a voice vote declared the motion carried and the House adjourned until 2:30 o'clock Tuesday afternoon.