outlived their families or their families have moved away from them and therefore they do like to get together and exchange tales of their activities and so forth. They have a camaraderie which I think is unique.

Mr. HERRIDGE: That is a very satisfactory explanation, Mr. Chairman.

Mr. CLANCY: Mr. Chairman, I have listened to some of my colleagues and I would like to have a definition of the three types of care, because they are all different, so that we all know what the member from some place in Toronto is talking about.

Dr. RITCHIE: Well I think it is pretty difficult to define what is an active treatment case, and when this active treatment becomes chronic, and when it becomes domiciliary. All I can do is give you our interpretation of this and some of the factors that govern it.

We are all aware of what goes on in civilian hospitals which are there for the care of active treatment patients, and we have the same situation in our own hospitals where a patient comes in for acute care. Once this period of acute care is over, then the patient is either discharged home or he becomes chronic. In other words, further treatment is not going to be of any material benefit. But until that patient can be transferred to a chronic care facility he has to occupy an active treatment bed, and this is one of the main difficulties I think in our hospitals at the present time, not only departmental but all of our hospitals; they are faced with this problem too. There are not adequate chronic care facilities available to receive these patients who no longer require acute care.

Now the chronic care patient, as I indicated, is the one for whom further treatment is not likely to materially change his condition. He is going to become a chronic invalid and he will either progress to become a domiciliary care patient or he will be deceased; that is all. So his course is downwards.

Now if a chronic care patient, through rehabilitation, through physiotherapy and occupational therapy can be given enough support that he can look after his own every day habits, well then he can become a domiciliary care patient and be provided with accommodation with very, very limited nursing care or treatment facilities. He needs a place to live.

Mr. CLANCY: Well, that is the answer. Domiciliary care is to get the man rehabilitated far enough so that he can dress himself, he can go to the dining room, he can look after himself; he does not need constant bed care?

Dr. RITCHIE: That is correct, yes.

Mr. HERRIDGE: Mr. Chairman, could we now hear from Mr. Pelletier.

Mr. Chairman, would Mr. Pelletier mind explaining to the committee the policy of the department with respect to purchasing supplies for our hospitals and for other services rendered other than by the staff.

Mr. PAUL PELLETIER (*Deputy Minister, Department of Veterans Affairs*): Mr. Chairman, with regard to purchases of service and purchases of any kind, I am sure you are all aware of the fact that from the 1st of April this year our purchasing services have been transferred to the Department of Defence Production under this centralized scheme of purchasing for all government departments. We were one of the first departments to do this and it has involved