of the Ridgewood health and occupational centre, which is equipped as a rehabilitation institute. It has a capacity of about 100 beds and we have been using only 30 of these beds as domiciliary care beds. The centre is equipped as a rehabilitation institute which will be useful to New Brunswick as such. Arrangement has been made with the workmen's compensation board of New Brunswick to take over the administration of this place and continue to give us the use of the 30 beds we are using, so we we are not losing anything. We are contributing something to the province which will be extremely useful to them.

In Sunnybrook hospital we had two wards empty which I was unable to staff with nurses. We have rented these wards to Wellesley hospital to establish an arthritic unit. This is a different thing than opening our doors to civilians because civilians here are being admitted to the Sunnybrook wing of Wellesley hospital. The staff is supplied by Wellesley. We are selling them meals; we are selling them heat and we are selling them cleaning services. We are renting them a certain number of square feet of ward space at so much a square foot.

In Edmonton we have come to an arrangement with the province whereby we are trading the 75 bed domiciliary care institution at government house and the old Wells pavilion of university hospital which was in an advanced state of decay and, in my view, was not suitable for patient accommodation for a modern 150 bed institution close to the university hospital, which will serve us as a domiciliary and chronic care institution. We are helping in this financially in that we are assuming part of the cost of construction. But, as a result of this we will find that our veterans are being accommodated in a new, modern building instead of in the Wells pavilion, which was completely unsuitable, and instead of in government house, which was beginning to cost us a tremendous amount of money to maintain.

That is about as far as we have gone in respect of the implementation of the policy which was expressed. There are still a couple of places where we may go further, but until there is a greater demand and a greater interest on the part of the agencies which we would consider competent to take over these institutions I think that there will be no further advances.

Mr. CHATTERTON: Would you distinguish between chronic and domiciliary care cases so that a layman could understand the difference?

Mr. CRAWFORD: Here we are getting into an exercise in semantics, which is always dangerous. Obviously, it is impossible to draw a sharp line of distinction. But, in general terms, a person whom we regard as a domiciliary care patient must be able to get out of his bed by himself, get over to meals, to totter around to some extent and so on. A chronically ill patient, on the other hand, may or may not require a tremendous amount of nursing care. He may be completely bedridden and he may have to be turned in his bed because he is unable to turn himself. But there is for him really no hope of improvement; he is going to deteriorate slowly, perhaps blessedly more quickly, until he dies.

Mr. CHATTERTON: Which of the groups will require more medical care apart from nursing care?

Mr. CRAWFORD: Well, of course, the medical care is minimal in the case of the domiciliary care patient. We have sick parades. We have a visiting doctor who talks to these inmates at regular intervals and finds out if they have any medical complaints.

The chronic care case does not require much in the way of medical care unless there is some aspect of rehabilitation, and this sometimes is possible.