treatment which could be provided in a good chronic disease hospital. Only five per cent of our patient load was in need of the kind of acute, intensive care which our hospitals were originally designed to provide and which they are now equipped to provide.

This situation is causing problems. It has resulted in a decrease of interest in our institutions as medical teaching institutions, with the subsequent diminution of interest by the kind of professional staff that we have and on which our enviable reputation has been based.

In my view, the only way in which we can maintain the standard of treatment which we have established in our hospitals is to dilute this aging chronic disease population with patients of a younger age group and with more active disease.

How can this be done? There are perhaps two possibilities. The first is to open the doors of our hospitals to patients from the general community. This is fraught with a great many very grave disadvantages. In the first place, if you are familiar with the British North America Act—and I have no doubt you are—you will realize that the operation of hospitals and questions of health are strictly reserved to the provinces, with the exception of the old maritime quarantine hospitals which were a federal responsibility. It is true that the Department of Veterans Affairs Act allows the minister to make regulations governing the operation of hospitals for veterans. This raises a very interesting question of whether this part of the Veterans Affairs Act was indeed ultra vires of the parliament at the time it was passed, but I do not suppose anyone is going to challenge that.

There is a difficult and important constitutional problem because many provinces are extremely jealous of their prerogatives in this field.

Another disadvantage of opening our doors to community patients is that the medical profession would not be happy with this sort of arrangement unless indeed we opened our doors not only to patients but also to all community doctors, and this would strike at the policy which we have clung to very firmly for very many years of having closed staff hospitals, and on which we have relied for our maintenance of treatments standards.

Perhaps you feel that the attitude of the medical profession is not important in this connection, but it is important to me apart altogether from what my personal views might be. It is important to me because I am entirely dependant on the good will of the medical profession to staff these hospitals. We have very few full time physicians. The majority of our physicians are on a part time basis. We obtain them from university staffs. It is important to me that my relationships with the profession in the maintenance of these staffs is maintained.

Another consideration which I think is worth remembering is that our hospitals are filled with veterans with one degree of entitlement or another. We are operating at pretty close to 90 per cent capacity on an average. So, for every non-veteran we admit to our hospitals some veteran is going to have to be discharged some place else.

And, if I might have the temerity to say, one of the disadvantages of this solution rests with gentlemen like yourselves. Not a day passes that I am not subject to some degree of pressure to admit to our hospitals veterans or quasi veterans who are constituents of one or the other of you.

Mr. HERRIDGE: What is a quasi veteran?

Mr. CRAWFORD: One illustration of this, Mr. Herridge, is a young lad whose father was a veteran. His father served very well. The boy himself has no service. However, I am being pressed to admit him to one of our hospitals because of his father's service. This is the sort of thing I mean.

Mr. HERRIDGE: That is a new one to me.