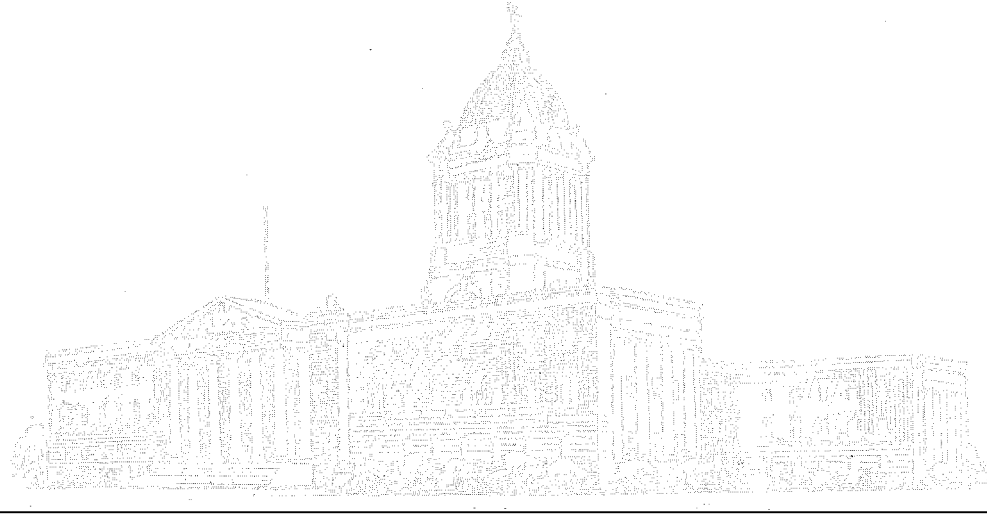
Legislative Assembly Of Manitoba

DEBATES and PROCEEDINGS

Speaker

The Honourable A. W. Harrison



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THE LEGISLATIVE ASSEMBLY OF MANITOBA

2:30 o'clock, Wednesday, March 14, 1962

Opening prayer by Mr. Speaker.

MR. SPEAKER: Presenting Petitions.

MR. JAMES COWAN, Q.C. (Winnipeg Centre): Mr. Speaker, I beg to present the petition of Harry Shnoor, praying for the passing of an Act to validate a certain devise in the last will and testament of Esther Shnoor, deceased.

I also beg to present a petition in place of the Honourable Member for St. Vital, the petition of Frederick J. Douglas and others, praying for the passing of an Act to incorporate the Church Home for Girls.

MR. SPEAKER: Reading and Receiving Petitions.

MR. CLERK: The petition of Trafalgar Savings and Loan Association praying for the passing of an Act to amend an Act to incorporate Trafalgar Savings and Loan Association.

MR. SPEAKER: Presenting Reports by Standing and Special Committees.

Notices of Motion.

Introduction of Bills. The Honourable the Minister of Education.

HON. STEWART E. McLEAN, Q.C. (Minister of Education)(Dauphin introduced Bill No. 73, An Act to amend The Public Schools Act (2).

MR. SPEAKER: The Honourable the Acting Minister of Municipal Affairs.

HON. JOHN THOMPSON, Q.C. (Acting Minister of Municipal Affairs)(Virden) introduced Bill No. 69, An Act to amend The Municipal Board Act.

MR. SPEAKER: The Honourable Member for River Heights.

MR. W. B. SCARTH, Q.C. (River Heights) introduced Bill No. 29, An Act to incorporate Secured Investors Association.

MR. SPEAKER: We have with us this afternoon students, 114 in number, from Lincoln School. This school is situated in Assiniboia constituency and is represented by the Honourable Member for Assiniboia. I might say that the group of students are in charge of Mr. Shildon, Mr. Sigfusson, Mr. Harapuik and Mrs. Friesen. We hope that their visit with us this afternoon will be instructural in nature and they may have a pleasant afternoon with us.

MR. SPEAKER: Orders of the Day.

MR. RUSSELL PAULLEY (Leader of The New Democratic Party)(Radisson): Mr. Speaker, before the Orders of the Day I would like to direct a question to the Honourable the Attorney-General. Could the Honourable Minister tell us when legislation will be introduced to regulate the manner in which charges made in connection with credit purchase transactions are set forth for the information of the parties to such arrangement?

HON. STERLING LYON (Attorney-General)(Fort Garry): Mr. Speaker, I would expect that that legislation will be introduced shortly.

MR. SPEAKER: Orders of the Day.

MR. GILDAS MOLGAT (Leader of the Opposition)(Ste. Rose): Mr. Speaker, before the Orders of the Day I'd like to direct a question to the First Minister. Some time ago I asked him for the details on the arrangements with Ottawa for the Greater Winnipeg floodway, the Shellmouth dam, the Portage diversion, and he promised that he would get this to us as quickly as possible. If we are to have a full debate on this subject I would again request that we get this very soon, Mr. Speaker, because it will require a fair amount of checking.

HON. DUFF ROBLIN (Premier)(Wolseley): Mr. Speaker, I'm glad to answer the question and tell my honourable friend that the principles of negotiation which have been agreed upon will be very clearly set forth in the House shortly, and I think they are such that members will have no difficulty in grasping their significance without any detailed or prolonged study. The actual agreement itself based on these principles is under negotiation and I'm not aware that I can tell my honourable friend when that particular agreement will be ready for public discussion.

MR. SPEAKER: Orders of the Day.

HON. GEORGE JOHNSON (Minister of Health)(Gimli): Mr. Speaker, Annual Report of the Alcoholism Foundation of Manitoba.

MR. SPEAKER: Orders of the Day. The Honourable Member for Rhineland.

MR. J. M. FROESE (Rhineland): Mr. Speaker, I have a few questions that I would like to direct to the First Minister, who is also the Provincial Treasurer. Question No. 1: The total amount of direct debt of the Province of Manitoba as of December 31st, 1961; No. 2: The total amount sinking funds will provide to cover the indebtedness in effect at December 31st, 1961, when same become due for payment; and No. 3: The balance or amount that will have to be reborrowed.

MR. ROBLIN: Mr. Speaker, if my honourable friend will submit an order for return it can be considered.

MR. SPEAKER: The Honourable Member for St. George.

MR. ELMAN GUTTORMSON (St. George): Mr. Speaker, I'd like to direct a question to the Minister of Agriculture. Could he tell the House what action he has taken to persuade his counterpart in Ottawa to pay acreage payments to those farmers who provide crops of alfalfa?

MR. SPEAKER: Orders of the Day.

MR. MOLGAT: Is the Minister answering or . . . . ?

MR. SPEAKER: He's not required to answer.

HON. GEORGE HUTTON (Minister of Agriculture & Conservation)(Rockwood-Iberville): Alfalfa is a cultivated acreage and acreage payments to my knowledge are made on the basis of the cultivated acreage of the farmer. -- (Interjection) --

MR. S. PETERS (Elmwood): Before the Orders of the Day I'd like to direct a question to the Minister of Labour. Last week we asked him when we could expect the legislation under The Labour Relations Act. He said he was in the process of polishing it up. I wonder if he could tell us how much polishing he's done and when we can expect it.

HON. J. B. CARROLL (Minister of Labour)(The Pas): Mr. Speaker, there'll be no undue delay in presenting that Act before the House. I will say that it won't be too long now.

MR. DAVID ORLIKOW (St. John's): Mr. Speaker, I'd like to direct a question to the First Minister. I wonder when we can expect the resolution dealing with the government's policy with regard to health which was mentioned in the Speech from the Throne.

MR. ROBLIN: I expect it will appear in the Votes and Proceedings either tomorrow or the next day.

MR. MOLGAT: Mr. Speaker, before the Orders of the Day I'd like to address a question to the Minister of Welfare. I today received a letter from a person out in the country having just received a letter from the Department of Welfare saying that they have been advised that their Old Age Security has been increased by $10.00. "Our regulations stipulate that this increase must be taken into consideration in computing the amount of Social Allowances to which you are eligible. Therefore effective April 1, 1962, your Social Allowance from this department will be reduced to $15.00 per month." The letter from the people writing says that this is the greatest injustice done to any man by any government. "This man is 92 years of age, no money and also blind. To give it to him with one hand and take it away with another, is tragic. Please look into this matter for his sake." Could the Minister indicate whether the review that he talked about yesterday is proceeding with all haste and when he may advise the House?

HON. JOHN A. CHRISTIANSON (Minister of Public Welfare)(Portage la Prairie): Mr. Speaker, I wonder if the honourable member would be good enough to table that letter so that we may be able to give it consideration and, as I have already informed the House, the review is proceeding and will continue.

MR. SPEAKER: Orders of the Day.

MR. PAULLEY: Mr. Speaker, before the Orders of the Day I wonder if I may direct a question to the Minister of Education. When will the study be completed in respect to the Manitoba Teachers Retirement Allowances Fund, and following that, when might we expect the urgent amendment announced in the Speech from the Throne in connection with the same?

MR. McLEAN: Mr. Speaker, there will be an opportunity of discussing this matter on the estimates of the department and the legislation will be introduced in due course in this session of the Legislature.

MR. SPEAKER: Orders of the Day.

MR. NELSON SHOEMAKER (Gladstone): Mr. Speaker, I would like to direct a question

(Mr. Shoemaker, cont'd.) . . . . to the Honourable the Minister of Agriculture. Is it a fact that a farmer can obtain a permit book even though he does not deliver grain to an elevator?

MR. HUTTON: Mr. Speaker, as I understand it, if he has never delivered any grain to an elevator he cannot get a permit book unless -- well, let's put it this way, he isn't eligible for a permit book unless he has some grain to deliver to the elevator. However, there are cases in respect of acreage payments where a man may have had a permit book in a previous year, he may have delivered grain, but he has neglected because of crop experience, or a loss of his crop, to apply for a permit. In a case such as this he can get a permit book and he qualifies on the basis of his past performance for an acreage payment. However, if he is not a producer of grain, marketable or commercial grain, then he does not qualify for an acreage payment.

MR. SHOEMAKER: . . . . . a question, Mr. Speaker. Let us suppose that a farmer, the last permit book that he held we'll say was five years ago and since that time he has changed his operations now to where he's growing nothing but alfalfa, sweet clover and legume crops. Would he be able to obtain a permit book which then would enable him to obtain acreage payments? Because you can't have the one without the other, I understand.

MR. HUTTON: If he isn't growing any grain and hasn't grown any grain for the past five years, I doubt if he can qualify for a permit book.

MR. SPEAKER: Orders of the Day.

MR. PAULLEY: Before the Orders of the Day, I would like to direct another question to the Honourable the Attorney-General. When will we be considering ways and means of domiciling the British North America Act in Canada.

MR. LYON: Shortly, Mr. Speaker.

MR. PAULLEY: A supplemental question, Mr. Speaker. The answer to my previous question from the Honourable the Attorney-General was "shortly". May I have the assurance of him and all of the front bench opposite that the Ministers do not bring in all of the resolutions as presented and announced in the Throne Speech at the same time under the guise of "shortly", because of the fact that at that time we will not be able to give due consideration to all of these very important matters.

MR. ROBLIN: Mr. Speaker, I'm usually held responsible for the management of the business of the House from this side -- perhaps I should reply. And my reply is to repeat the assurance I already have given the House to the effect that these resolutions and the bills that members are waiting for will be introduced in an orderly fashion to the House so that we may have, relatively speaking, one at a time before us for discussion, and I anticipate that there will be sufficient time to do justice to the various important matters that we have had to bring down. I want to repeat that assurance and tell my honourable friend that just as I said a few minutes ago that the bill on the Health and Medical Plan will be -- the resolution on the Medical Plan will be down shortly. That means in the next day or so, and I expect that very soon after that the Constitutional Amendment resolution will come in as well, so that we will get a relatively even presentation of these matters before the House, and I think that ought to meet with the convenience of the members.

MR. PAULLEY: Mr. Speaker, may I say that I appreciate the remarks and the answer of the Honourable the First Minister. I take him at his word. May I suggest to him that it would be better for us in opposition if, rather than the loose term of the word "shortly" that if he could announce to those of us in opposition that a plan -- that this week we would have this resolution, say for instance, dealing with the constitutional amendment, next week with this, that or the other, in order that we may prepare our material and give consideration in an orderly fashion to these very important matters. Discussions have been taking place, or have taken place in the House, the matter in connection with the lack of research that is available to both the Leader of the Opposition and myself, and I am sure that the Honourable the First Minister will appreciate our predicament in respect of that. It would assist us materially if we could have and I agree with him, that this will be done in a regular sort of a basis, a resolution or two this week and another one next week, but I'm sure that it would facilitate the business of the Province of Manitoba and give us a better opportunity to give due consideration to all of these important matters if we had a time-table before us as to when these matters would be under discussion in this House and I appeal to the Honourable the First Minister to do this if it is at

(Mr. Paulley, cont'd.) . . . . all possible.

MR. SPEAKER: Orders of the Day. Adjourned debate proposed by the Honourable the Minister of Welfare. The Honourable Member for St. James.

MR. D. M. STANES (St. James): Mr. Speaker, I have listened with considerable interest to the debate on this resolution which are intended purely to permit Ottawa to bring in an additional service to that group of people who are, I feel, in such great need of assistance. I feel there are three ways in which these groups of people can be assisted. The first is in cash, the old-age security; the second way -- and by other assistance -- the second way is in kind, in housing, Medicare and such like, and the third way is the one which we are giving Ottawa permission to bring in, and that is a contributory pension plan. It appears to me from listening to the debate that everybody is agreed that this is a necessary addition to our service to our senior citizens. Everybody agrees that it is a senior and difficult legal problem which I for one am not qualified to speak on, and yet during this debate we brought in such things as the Honourable Member for St. George brought in, the fact that it was a difficult legal problem, that he was not learned in the law, and yet at the same time accused the Federal Government of throwing smoke screens and so on. I am afraid I cannot have any opinion on that subject because I don't know the problems involved in such consitutional law. The Honourable Member from Carillon brought in one or two points in the record of the Liberal Government in Ottawa which was well handled by the Honourable Member for St. John's, but he also brought in a question of 30 years, 40 years in power, and I don't know whether that was used as a compliment, that they stayed there that long, but I see no relation between that statement and the resolution which is before us. I also don't know how John Glenn got into the debate, as to whether they were up there during that period or there first, I don't know.

Mr. Speaker, I certainly will support this resolution because I think it is a much needed service. I shall also support it because I think it has been well considered in Ottawa. I note that as far back as January, 1958, the Prime Minister, in a speech, stated that such a service shall and should be added in this country. Since that date improvements have been made in the other form of service, in the cash. 1957 the pension was increased to $55.00. In 1960 it was extended to people outside this country and, of course, the recent increase. I don't know the details; none of us know the details of what will be brought in once Ottawa is permitted to bring in this legislation, and I know, I for one will look forward to receiving that with interest. There is one observation, of course, that should be made, that in anything, including that which is contributory, it will have to be paid for, and no doubt the people will have some choice in what the benefits will be in accordance with what they will pay. It is also needed, that I mentioned, Mr. Speaker. I feel that there is a distinct gap between the need and that which is covered by the commercial insurance field. I am also satisfied in my own mind, having studied this thing a little that it will not conflict with the commercial insurance. Apparently it will pay, so we gather so far, to age 65 or over, and in cases of sickness and accident to those before that time. So it will provide a very necessary service to our senior citizens.

It is rather interesting to note, Mr. Speaker, some figures that I have here, that the percentage of the labour force in 1953 in Canada was 14.4 out of a population at that time -- (Interjection) -- I beg your pardon? This is those participating in some or all forms of insurance in the form of pensions. In 1953 it was 14.4 of the labour force; 1957, 22.7; and in 1960, 26 percent, which really is a very small percentage of those who are the working force of this country. In Manitoba it is also interesting to note that the percentage of people of the population of Manitoba who are over 70, in 1951, 4.9; in 1956, 5.6, and in 1960, 5.9. So I think it's very clear that such an additional service is needed in Canada and in this country.

One further point, Mr. Speaker, I would like to raise, and that is I was very interested in the Minister when he proposed this resolution that he mentioned that this plan is fully portable. I think this is a very important fact. I think the Honourable Member from St. John's mentioned this. I think it's equally important, Mr. Speaker, for other insurance. I know, as most of the honourable members know, of several cases where there has been considerable hardship to people because of the lack of portability of existing commercial pension plans. Two particular cases that come to my mind is the type of person who has an opportunity of improving his position but cannot take it because of the loss of his investment in the pension plan; therefore he refuses that up-grading position, and that position is lacking this particular person. There

(Mr. Stanes, cont'd.) . . . . is another case which I know about personally whereby a lady who left her employment to go to another job which had a greater challenge; she accepted that job, and having taken it discovered that the pension plan which she had was not portable and she lost it, just took out the money which she had invested in it. At the same time she found out that being over 50, she could not join the pension plan of the company which she joined, so I do hope, Mr. Speaker, that everything will be done to try and make all pension plans portable. I am aware of a Royal Commission in Ottawa which I feel is still studying this problem, but I do think it is a problem which is creating considerable hardship, not only to the individual, but I think it's restricting proper movement within our province, within the country, and I do hope this government will do all they can through Ottawa to get all pensions portable.

MR. D. L. CAMPBELL (Lakeside): Mr. Speaker, this is an interesting resolution, and like those who have preceded me in discussing it, I certainly do not pose as a constitutional expert. It has been referred to as a constitutional resolution and I suppose to some extent it is, and I shan't spend any time in dealing with the necessity of it from a constitutional point of view as I am not competent to give an informed opinion on that matter. I guess the fact that the Federal Government asserts that they think it is necessary means that we need to go along with it in order to get the change made that is suggested. That's all I care to say about that. I would be inclined to agree with the position taken by the Honourable Member for St. John's that when the present Prime Minister of Canada was campaigning and saying that he was in favour of a contributory pension scheme, that he should have pointed out at the same time that it would have to have a constitutional amendment in order to put it in, and then having achieved office he should have perhaps moved a little more quickly than this, but that's water under the bridge at the present moment and I have no strong words to use in that connection because apparently it's one of the fallibilities of we human beings that we make these various mistakes. I don't intend to characterize it as a hoax or anything of this kind, although I think myself that it is probably unnecessary.

Then too, the question has been raised in connection with this particular resolution as to the domiciling of our constitution, or the BNA Act in Canada. Well that's another interesting discussion or subject, but, Mr. Speaker, I think it would be well for the members to remind themselves that in all the discussion that has taken place regarding the domiciling of the constitution in Canada that it's not the government of Britain that is holding us up. They have never refused to let us bring our own constitution home to our own country. They, I think on the contrary, have made it quite plain that they're willing to do it. The reason that it's not been done is that we folk in Canada have as yet not been able to agree on the method of doing it. But in the meantime, in the meantime, I think that the position is undoubtedly this, and I believe all the experts would agree with me in this matter, that the British Government has made it abundantly clear that in the meantime so long as they have the responsibility for passing the actual amendments to the BNA Act that they will pass those amendments on the advice so to do of the Government of Canada. I think there is no question that -- and this is one of the reasons that it seems to me that the provinces of Canada should be anxious to get some form agreed upon of amending the constitution and particularly those provinces that are very, very jealous of the provincial rights should be the ones that should be in the very forefront of the movement to get an approved method of amending the constitution here at home, because in the interval it simply means that whatever government is in Ottawa, without asking the consent of any province at all, can get an amendment if it so desires. I think we need to remember that and I have had the pleasure at conferences years ago of pointing out to the representatives there of the Province of Quebec that it was certainly, in my view, to their interest to work diligently toward getting an approved method of amending the constitution, because in the meantime they have no power of veto over even the most precious clauses to them.

So let's be clear on this, Mr. Speaker. The fact is that if the Federal Government asks the Government of Britain to amend the constitution they will do it. Now then, -- (Interjection) -- without consent of anybody but the Federal Parliament. The Federal Parliament in the meantime and the British Government is quite anxious also I think -- I can't speak for them -- but I think they're quite anxious to see that a method is arranged in Canada by which there will be an approved program for getting amendments so that they are relieved of that position, but in the meantime that's the position they adopt. Therefore, it brings me from that angle to a discus-

(Mr. Campbell, cont'd.) . . . . . sion of the necessity of this amendment. I say that this amendment is not necessary -- I mean this resolution is not necessary, because the Federal Government by making representation to the Government of Britain can get the amendment, but I don't oppose it for that reason. I don't even criticize it for that reason, because I think quite frankly that it's at least a courtesy, at least a courtesy for the Federal Government to ask the provinces to agree to it; and they did more than the courtesy. I think it's probably good business inasmuch as conferences have been proceeding and will be proceeding, unless they have been completed, with regard to federal, provincial co-operation in arranging a plan for amending the constitution, that it's good business to recognize the provinces' interest in these matters so that they will perhaps . . . that method, be a little more interested and a little more co-operative in the programs that are taking place. But I repeat, there is no necessity as I understand it, no necessity whatever of the Parliament asking that to be done, and so I am quite willing to go along with the resolution as it's been previously stated as far as we are concerned. I doubt that the paragraph accurately reflects the situation when it says that it appears that Parliament cannot validly enact legislation for the purpose mentioned. Opinions differ on that and I am not competent to judge between them.

Then when it says that this House concurs in an address being made by the Government of Canada to Her Majesty the Queen requesting this enactment, well I don't think it's necessary, but I don't see that we need have any objections. And if that's the way the Parliament of Canada or the Government of Canada has decided to do it, I think we might as well go along with it. But in the final paragraph, " and that in the opinion of this House, it is desirable that failing the enactment of the amendment to the British North America Act 1867, the Parliament of Canada should enact legislation," Mr. Speaker, I am sure there will be no failure if the Parliament of Canada asks for it. We don't need to consider the possibility of failure because it has been decided in cases over many years and I think made particularly clear after the passing of the Statute of Westminster that if the Parliament of Canada asks for this, they will get it. Now I say again, I see no objection to them asking the provinces. It's at least courteous; it's the diplomatic thing to do perhaps, but if they don't get the consent of the provinces, if they still want to do this, if they're really sincere in wanting to put this in, then all they need to do is ask the Parliament of Britain to do it and it will be done.

MR. T. P. HILLHOUSE, Q.C. (Selkirk): Mr. Speaker, I would move, seconded by the Honourable Member for Emerson that the debate be adjourned.

MR. SPEAKER: Does the Honourable Member for Rhineland wish to speak?

MR. FROESE: No, I was going to adjourn it, but it's . . . . .

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

MR. SPEAKER: Committee of Supply.

MR. ROBLIN: I move, seconded by the Honourable Minister of Industry and Commerce that Mr. Speaker do now leave the Chair and the House resolve itself into a Committee to consider of the Supply to be granted to Her Majesty.

Mr. Speaker presented the motion and after a voice vote declared the motion carried and the House resolved itself into a Committee to consider of the Supply to be granted to Her Majesty, with the Honourable Member for St. Matthews in the Chair.

MR. CHAIRMAN: Department XIV, Resolution 87 passed - -

HON. GURNEY EVANS (Minister of Industry & Commerce)(Fort Rouge): Mr. Chairman, I think I have just one question that I did not answer for my honourable friend from Rhineland. He asked whether the earnings of the Fund were on an accrued or a cash basis. The answer is, an accrued basis.

MR. MOLGAT: Mr. Chairman, it seems to me that we left this item standing last night at the request of the Minister of Agriculture. Did he have some comments he wished to make on the subject? Most unfortunately, Mr. Chairman, he's not in his chair. I suppose that he'll save his comments for some other occasion.

MR. CHAIRMAN: 87 passed.

MR. PAULLEY: Mr. Chairman, before we pass that item, I asked the question yesterday in respect of the annual amounts that we are showing in our estimates and posed the question as to why these should not be shown as liabilities against the company, or against the corporation, and I am not quite sure of the answer of the First Minister as to why this should

(Mr. Paulley, con'td.) . . . . not be done, and the objective that I had was very, very obvious because of the fact of these items being in estimates are only revealed by going back over the year. Actually in my opinion, I think that I had some agreement with the Provincial Treasurer on this, that technically these are proper liabilities of the Industrial Development Fund, and if eventually that the Fund gets into a position of being able to reimburse the Provincial Treasury or the taxpayers of Manitoba for these funds, it would do so, and I wonder, Mr. Chairman, whether the Provincial Treasurer could pursue this particular matter and this thought that I have. First of all, is there any logical reason why the cumulative amounts that we provide in the estimates for the Fund, and particularly at this stage, should not be carried as a separate liability -- I am not conversant with Chartered Accountancy -- so that the amount would be shown as they accumulate in the annual statement of the Fund of advances from the Treasury of the Province of Manitoba to them, so that we would have readily available to us as we consider the annual statements of the Development Fund, the amount advanced for this purpose?

MR. ROBLIN: Mr. Chairman, there is really very little I can add to the discussion of last night, except to say that if we followed my honourable friend's suggestion then the item would disappear entirely from the current revenue estimates, the current expenditures estimates that we have here. -- (Interjection) -- That's not your proposal? Well, I think that would be the case, though, because if it was shown as a liability of the company then it would be transferred to their books, it would disappear from these here; and it seemed to us that on the whole we would be wiser to have it in the current estimates every year, to let the members know exactly what the state of affairs was here, just in the same way as we do with the Agricultural Credit Fund. Now, I see my honourable friend's point. There's some logic to it; I'm not saying that it's not worth considering, but I reiterate our view that we think this is just as good a way of doing it, and has the result of placing the item in the current estimates where we think it ought to be.

MR. PAULLEY: Mr. Chairman, I am not suggesting that it should be deleted from the Current Estimates, but what I am suggesting is that in the annual report of the Development Fund, that it be shown in that annual report; that say, for instance, in the estimates of the year 1961 - 62 there was an advance of $213,000, for '62 - 63 there's $258,000, and this be accumulated as the years go on and then transversely when the amounts are recurring back into the treasury. That's the proposition.

MR. ROBLIN: Mr. Chairman, I think probably we can consider a different way of doing this. I won't give an undertaking but I will ask the Fund to consider showing these amounts, perhaps as a footnote of some sort in their statement so it will be available there as well.

MR. A. J. REID (Kildonan): I wonder if the Minister could inform us, when people apply for a loan, how it's processed. Because it's been established now that Custom Abattoirs have got a loan from this here Fund and a fellow phoned me up and he understands that Custom Abattoirs, the personnel that had access to this loan, are quite active in quite a number of other businesses in Greater Winnipeg area, and he was in that area in business for quite a number of years and he approached this here fund, or the men on this fund, for a loan and he said he had quite a difficult time. He couldn't get to first base with them, and yet he says another enterprising group came along that control quite a number of businesses in the Greater Winnipeg area and he says they quite easily got a loan, and he had all the assets and everything to pass for the loan and they turned him down. I don't want to mention any of these men involved in it but if the Minister wants it I can give them to him, and yet they got a loan very easily. This individual, they turned him down.

MR. EVANS: I take it that the one who received the loan was able to convince the board of the Development Fund that, first, they had a proposition which could make money; second, that they had qualified management to run the plant; third, that they had sufficient capital of their own to invest as equity capital.

MR. REID: If we had a list of where the government is loaning this money to, then we could decide. But we get these complaints, and these people have a legitimate complaint, because they've got a list of these businessmen who got this loan, and they know, and they come before this Fund, they couldn't get two cents. So there's something the matter there. The Minister should give us a list of names and these firms that get these loans so we could decide here.

MR. CHAIRMAN: . . . . . passed.

MR. MOLGAT: I'd like to ask one more question of the Minister. Is it correct then that any of the firms who have obtained money from the Fund were unable to get the money from other sources? That was one of the provisos, I think, that he indicated last night. Now is it correct to say that all of those who received money were in that category?

MR. EVANS: My understanding is -- I don't know the particulars of any loan that has been either negotiated or given by the Manitoba Development Fund -- I do know that the requirement is that they shall be able to demonstrate to the Fund that they have consulted other sources of capital and have not been able to obtain their requirements at reasonable prices.

MR. CHAIRMAN: . . . . . passed.

MR. ROBLIN: Mr. Chairman, I'd like to inform the committee that we will now be proceeding with the estimates on the Department of Health, which was a piece of information previously supplied, and to say that after the Department of Health we will be dealing with Mines and Natural Resources.

MR. MOLGAT: Not Municipal Affairs?

MR. ROBLIN: No, the Minister has asked me to make a change in that so we will be bringing that in later on.

MR. ORLIKOW: Mr. Chairman, before the Minister begins I think I want to raise a matter which I think is important. It is being said that we, and I suppose with justification, that we are moving quite slowly in the consideration of the estimates. I think all members want to get on with the business as quickly as possible but I want to say, Mr. Chairman, that for myself it's pretty difficult to proceed expeditiously and rapidly with a department as big as the Department of Health when we haven't even got copies of the annual report. There are questions which I want to ask, and I'm sure that there are questions which other members want to ask, which may very well be answered in the annual report, but we haven't got them and so all we will have will be the statement of the Minister, and the Minister can't possibly deal with everything. We have nothing in front of us in writing, so even those things which he deals with we have to do it as well as we can just by listening to him. Those things which he doesn't deal with we have to guess at and I think that this is completely unsatisfactory. Now these are reports which are not even for December 31, 1961. I understand that these are reports for the year ending somewhere last -- about a year ago. Why they can't be ready -- I know that it was tabled, the statutory provision I assume was lived up to, it was tabled in the House here, and then it went to the printers I suppose, and I suppose every year we hear at least ten times that we're doing as well as we can but the printer just isn't ready. But I want to say as far as I'm concerned this just isn't good enough. There's no reason why the report can't be ready and can't be in the hands of members in sufficient time so that the members can give real consideration to the report and the department and the matters in which they are interested in, and this not being so, Mr. Chairman, it seems to me that the work of the committee must by very nature be slowed down. After all, the members on this side of the House have just as big a responsibility to the people of their constituencies and the people who elect them as the members on that side of the House and if we are not supplied with the factual information by the government it's difficult for us to do our work. Now there are departments we have had reports on. We've had the report of the Department of Public Works. Now why can't we discuss that? We've had the report of the Department of Education. Why can't we discuss that? There may be reasons -- I don't know what the reasons are, but I want to say as far as I'm concerned I find this completely unsatisfactory.

MR. CHAIRMAN: Department VIII . . . . .

MR. JOHNSON (Gimli): Mr. Chairman, in answer to the honourable member re the annual report, I was going to mention this. We tabled the annual report as you know and we -- the Minister of Health in the past, as this is quite an extensive report, I believe in the past legally it's only -- let's put it that way, the Ministers' only responsible for tabling this report. In the past the Health Department has usually had a review of activities to present prior to estimates. Last year in lieu of our review of activities we made it a little bit dressier, on better paper, and tried to conduct an exercise within the department to produce a real nice little annual report that we could send out to our units as a matter of education at large in training of new people coming into the department, and so on. We were repeating that this year, and I

(Mr. Johnson, Gimli, cont'd.) . . . . must admit to the honourable member that I had hoped before coming to my estimates to have a copy of this in the hands of the House. However, I hope to have this -- on checking yesterday, this has been held up at the printers and I would hope to table this review of the annual report by tomorrow or Friday at the latest. I regret this very much. However, it might be of some guidance to have before you our review of last year which will be brought up. Of course, there are new figures and so on, but it might help the honourable member in directing questions to this department. I regret that we haven't got the review before you to guide you through the department but I can offer no other explanation at this time as the volume of the report at this time.

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

MR. JOHNSON (Gimli): I would like to, in introducing the estimates this year, as this is the new Department of Health, I want to first of all say again that I'm sorry that I haven't got the review of activities before you as we had planned, but I think my staff weren't sure just when I would be up and I must apologize for this.

Secondly, in looking over your estimates this year and in introducing them, I do feel I should review with the committee some of the activities that have gone on this year and make some mention of the many voluntary and other bodies which the Department of Health is in day-to-day contact with. You will note your estimates this year are $20 million, and as the honourable members know, you see in-and-out items here with respect to the public health grant, mental health grant, etc. These total 3.2 million and this 3.2 is the extent of our federal health grant, so really in the Department of Health we're spending upwards of $23 million. Now, first of all I want to tell the committee and share with the committee the pride which I think we in the Province of Manitoba should have in our staff, the many hundreds of employees in the department throughout our mental hospitals, in our public health education, rehabilitation and preventative health field, public health nurses, sanitary inspectors and so on. As I have moved around the province and met these people I find a very high degree of efficiency. I think we have great potential in these people. I believe that more and more we must invest in these good people and give them -- they're ready and willing to take more and more responsibility.

I think I would like to mention it's a matter of pride to our department that Dr. Atkinson, our Director of the School for Mental Defectives at Portage was recently invited to the White House as a member of the President's Committee on Mental Retardation, and also to announce to the House that our Deputy Minister of Health will be Canada's delegate in the public health field to the World Health Organization at Geneva this spring. I also would like to tell the House that we sometimes forget about our Provincial Board of Health which has functioned here for many, many years and still carries out pretty well the functions it did in the early days, and this committee, made up of senior members of the department plus representatives of the public at large, meets monthly and reviews the regulations which the technical and professional people in the department recommend to the Minister. I think this is a very worthwhile thing. You sometimes have a tendency for technical people to bring down very strict regulations which are often interpreted much better for us by lay people in the community who understand just how far maybe we should go in any of these measures, and I wish to pay a real compliment to our Provincial Board. . . . . the City Health Officers on this Board, I believe the Chairman now is a country doctor, Dr. Hudson of Hamiota, plus the Deputy Minister of Health, Mr. Flattery of our Sanitary Inspection Division, and other lay members. The Provincial Advisory Commission under the Health Services Act which is being amalgamated with the Advisory Hospital Council under our new Manitoba Health Council which will be in our Health Act, has served a very useful function over the years, and it was during this past year that one of the very senior and long-standing members of that commission body passed away, and I am referring to Mr. J. E. Ramsden of Dauphin who rendered long and very valuable service to this commission. Also the Hospital Council during the Willard Survey, as you know, were used as a sounding board as it were, for the committee and commission during their long study, and while they felt at times, I believe, that it was pretty hard to follow the day-to-day activities of the plan because they had been going forward at a terrific rate -- it's hard to keep all these people informed and especially when the Minister was going from one group to the other and carrying the same message forward and really necessary for the department to carry the initiative and make decisions.

(Mr. Johnson (Gimli), cont'd.) . . . . There are a host of voluntary agencies that the department depends on because, as I have often said, the Department of Health's activities at the local level are really meaningless unless we have public understanding and public concern. The people must want the service, and more and more we find that in the area of health, the people if it's a good service, well organized, they're willing to play their role in paying for it. This I am convinced of. One of the most tremendous stories that is told, that I can tell and I could spend a great deal of time, is the Canadian Mental Health Association and their branch of Share. When one looks over the reports from the institutions as to the number of visits, I would inform the House that at our Psychiatric Institute which the Member from St. John's will be glad to hear the name "psychopathic" is just about out of the picture, I have asked the -- (Interjection) -- Well, I've had assurance they're going to plaster it in for me some time ago now; I hope it is. Don't drive by there on your way home though -- but we are referring this now to the Psychiatric Institute. We've had certain difficulties here I'll mention later. We are carrying out a consolidation of all the mental health legislation. We've been working on it for a year now. I would hope that by next year it will be ready to present to the House. At the moment, right in the Act, the word "psychopathic" is written out and in all our correspondence -- we can't avoid the use of the word in official correspondence -- but the Canadian Mental Health Association now have approximately 5,000 volunteer members.

At Selkirk the list is as long as your arm as to the work they are doing. We have 100 volunteers a night in our new recreational facility at Selkirk, and it is booked ten days in advance for all sorts of activities, and the day to day -- the Open Door Club which they operate in Winnipeg, has actually gained such repute and has become so well-known that people seeking help have been referred from the Open Door Club to our psychiatric divisions. Three times a week there are visits in our Psychiatric Institute adjacent to the General Hospital, and in Brandon there is a very active chapter. These people are most dedicated and it is the spread of this type of activity of bringing the community to our institutions which is bringing about probably the most exciting story in health in this province which I'll refer to in a moment.

The Association for Retarded Children and Adults or the Association for Retarded Children -- their activities at the volunteer level of course are legend in our province and their activities in the past year have just about doubled. The Director of the Hospital at Portage sent me a memorandum the other day when I inquired -- I think this association, plus all its other activities, sent literally hundreds and hundreds of personal gifts to the inmates of that school in the past year plus about $6,000 in money to purchase little extras. This organization is, like its counterpart the Canadian Mental Health, are doing a real job for us in this province.

The Victorian Order of Nurses -- I had the pleasure of going to their annual meeting -- 14 percent increase in their activities in the past year. This is where they render -- playing a large role in home care and they're anxious to do more and more. I was happy that the Social Allowances Act has proved a real benefit to them in helping and working with other voluntary agencies in various home-care programs.

The Sanatorium Board of Manitoba; I think we probably in Canada have one of the strongest boards that I know of, where members of the board during the building of the Rehabilitation Hospital, busy businessmen, have been down every morning before the contractor in many instances, and making sure that our public funds are being spent wisely and well and that there is no cause for criticism in any way as to how they're operating, and with their tuberculosis -- with their days of care down as they are, they are very anxious to gradually, as I see it, get more and more involved in rehabilitation. And then we have the many voluntary hospital boards throughout the province who are carrying the day-to-day administration of our hospitals, and these again are dedicated people.

And then, of course, our four major rehabilitation agencies, the Society for Crippled Children and Adults, our Compensation Board, The Canadian Institute for the Blind, and our Sanitorium Board, work with the rehabilitation director in bringing about integrated service below the hospital plan. The Canadian Arthritis and Rheumatism Society is rapidly expanding its work in rural areas with treatment of -- in education and in actual treatment to severe sufferers of rheumatoid arthritis.

The Family Bureau -- we've used their housekeeper services to the point where we're running out of housekeepers now that so many married women work and so on. We have taxed

(Mr. Johnson,(Gimli), cont'd.)..... them.

And then we have the Canadian Red Cross, the Cancer Foundation with their activities, and all of these host of voluntary agencies, and I have only mentioned some of the more active ones. They're all active and pressing and bringing the community's interpretation of what its need is to the officials in the department every day of the week.

Within the Department of Health itself I think the highlights that I'd like to record with the members are the facts that this is the first polio-free year since records were kept in this province. It was 1918 that they started to keep records, and of course the department are hopeful and praying that in this endemic centre in North America we can be especially proud and hope that this will continue by all of us, both in and out of the House, encouraging young and old to avail themselves of these Salk and Sabin vaccines which are now available. They have far surpassed, I think, even the hopes and dreams of the most pessimistic of those who have for years worked in this area of polio.

You'll notice that the estimates largely provide for -- the biggest activity within the department is really in the area of mental illness. These estimates are up about $2.3 million since '58-59. This year they're up -- part of that is -- including this year they're up from $4.2 million to $6.2 million, almost a million this year, and I would report to the House that the activities of not only Share, the activities of the volunteers coming into our hospitals and carrying the people in the community, giving them support, individual treatment, more time spent by our hard-working psychiatrists in actually spending time with the patient, more occupational therapy, new drugs, our community mental health concept for which again we are asking for a 30% increase this year, and the Social Allowances Act as an instrument to help in many cases of need, has resulted in 176 less patients, numbers of patients in Selkirk and Brandon this year over last year -- 176 in the past year. I looked up the figures and since 1958-59 we have 268 less patients in hospital in our two large major facilities. Now I thought I would tell the committee what a wonderful thing this really is. In the town of Selkirk a group of interested citizens have purchased a building in which we are going to have a shelter type of workshop or activity centre in the heart of the town of Selkirk for those patients who the staff feel are ready for the half-way house on the way back to the community. They have raised considerable monies themselves and purchased this, and the department is making a contribution, of course, and the superintendent of our hospital there is working with the local people in developing this program. We have a contact man who is going to be on the staff, and these people are running this entirely on their own. It was their own idea after participating through Share in the activities at the mental hospital. The contact man's going to get jobs for them to do, starting doing less complex, then more complex work, and this is a wonderful step forward that we hope to stimulate. We mentioned, as honourable members have read, our submission to the Royal Commission on health, I think, contain the main feelings we have in the department that our best bet at this time is to try and invest as much as we can in more staff and good staff and give them more responsibility in this area, and you can't go wrong investing in good people, and we certainly feel that there's no reason why Ottawa should not share in the cost of mental illness any more than separating out any other disease.

There's the need to develop smaller hospitals, to, as I said last year, tear down those battleships out on the sands of rural Manitoba and in the future our concept must be to develop psychiatric units adjacent to or part of our acute chronic hospital facilities. Health is one and indivisible and you can't get away from that concept. In fact, I hope tomorrow to table for the honourable members the proposed program of capital construction in implementing the Willard report, and the hope that we -- and the decision of this Administration to put emphasis on the treatment of the mentally ill and in the area of chronic care.

I would also like to say that in mental health, the community mental health program is working out extremely well. To give the committee members an idea how we are starting, the staff for instance, working out of the Selkirk Base Hospital contact all the physicians in the eastern part of the province and the Interlake and that region, and tell them their services are available, and the object is to try and keep the patient in the community, to involve the family physician in his care and to be a resource to him instead of an ever increasing flow of patients into custodial care. And an example of this I have seen, and again the Brandon team, when I was up at Swan River this fall, the local health director was anxiously looking forward to a visit from

(Mr. Johnson (Gimli), cont'd) ....the psychiatrist from Brandon who came up that day, and in reviewing the cases there were at least 12 or 15 that are being kept in the community because of the continuing consultation and visitation by the experts in that field and supported between times by the physician, keeping the people as close as possible to their home and their own environment, and I think if any of us look a bit critically it's only common sense. If we were taken out of our homes and put out of sight and out of mind for any period of time, I think we would begin to change in personality, in aggressiveness, in our feeling of being wanted, and these are the things that it seems almost ridiculous we haven't realizedmany years ago, but it is these modern drugs, the tranquilizing agents in use today, the open-door policy where half our patients pretty well are on open wards, and the bringing the community to the people and bringing the staff to the people in their communities that is going to do the job. And I would go so far as to say that in another 10 or another 15 years we should be able to get along with 50% of the beds which we're now utilitizing for mental health. I would go even so far as to tell you that the provincial psychiatrist advised me recently that in the past year he would advise me that we would require half the beds in Greater Winnipeg than he would have recommended to me a year ago. The challenge is up to us to get the staff and get on with this job of creating smaller -- bringing the smaller mental hospitals adjacent to our acute hospitals and supporting our volunteers and so on. I would later on like to tell the committee of my experiences in other jurisdictions where the story is similar. I mentioned also, we're going to be reviewing our mental health legislation.

In the area of trainable retarded children, which is a function or a responsibility of this department, which started out by way of grants to the Association to support children in day schools, I must say, and I am quite familiar with the operations of this organization as is the member from Selkirk whom I met at quite a few of these gatherings, this organization has reached the point where they feel they either have to have an executive-director to assist them with their activities or to have someone appointed by the department to work with them. This hasn't quite been resolved, but you're going to be asked to pass monies to resolve this problem. We haven't decided just which of the two courses we will follow. However, it's imperative that -- I feel that the department become more involved with these people in seeking the best solutions in the public interest, and we intend to follow through with them. The number of children born every year to a degree of mental retardation is staggering; the need for research is paramount; some very wonderful research is going on in our province; some unique research, and with substantial federal and other support. I would tell you that there are close to 200 children now being maintained in the community in addition to the activities of the retarded children directly by the Department. In the maintenance of children outside of institutions there are now close to 100 -- 97, 98 children. Inside institutions there are at present 97, and you're going to be asked -- there are 85 at St. Amant, 12 in other homes in the province. You're going to be asked to pass estimates around $323,000 to maintain 110 children at St. Boniface Sanatorium. The Sisters there in the St. Amant ward are running what has been described to me by outsiders as the finest facility of its kind in Canada. I have had numerous letters from other provinces asking if there was any room for their child, for their children. I can tell the House that our need is great. The type of child that is placed in St. Amant is the child under 6 years of age who needs a high degree of care, medical care, and again here the parents, the Knights of Columbus are supporting the Sisters in many ways with the care of these children in this facility.

I would tell the Committee that as we see it in the department now, the challenge in the future in mental illness is not so much with the adult mentally ill as with the provision of those programs, facilities, research etcetera to combat retardation and the care of these children. This is going to be -- in the future more public money is going to be going into this area of mental health than into the care of adult mental, the adult mentally ill. In the past year the activities of the Association for Retarded Children will have increased from $56,000 we passed last year to $106,000 this year. This money, as you know, goes into maintaining children in day schools which the Association have created, in the promotion of day centres for those children who don't benefit from day school training, and the hope -- and I am going to table this for your further information -- the hope that in the not too distant future, in a year or two, we can get on with the development of experimental, development and pilot studies of shelter-type of

(Mr. Johnson (Gimli), cont'd) ..... workshop or facility for the trainable retarded child.

As you know again, we're opening this month a hundred -- which we hoped would open last October but it's been delayed for some reason -- the 180 beds at Portage la Prairie, this new facility, is opening this month. Since '58-59 we will then have opened a total of 320 beds at Portage la Prairie in addition to the activities I have just mentioned.

The other tremendous problem in mental health is in the area of child psychiatry. Again I will be giving more information on this, the need -- for acute psychiatric facilities for children do not exist in the Province of Manitoba in any entity and it is felt that this is one of our priorities, to get on with the development, as we have been advised of at least 15 acute psychiatric treatment beds for children. I think we should work with the Children's Home in developing the type of care facility, non-hospital type of setting for the child who needs care and treatment beyond two to five months, to get these children out of the acute facility as soon as possible.

We are going to help and promote a development of the pre-school development centre which has been started at the Children's Hospital which certainly needs reinforcement and psychiatric staff to act as an assessment centre for our various voluntary agencies, The Society for Crippled Children, The Association for Retarded Children -- they can all use the same medical consultive service if we develop a good one in the Children's Hospital. I have spoken to the Board of the Children's Hospital and they're going to consult with the various bodies as they plan their new facilities.

Also, we feel with acute adult facilities we need a facility in Winnipeg. The government has given top priority to speaking to the General Hospital, who have not yet visited me, who have received a letter from me which I will talk about later, where we hope to involve the hospital in the development as soon as possible, of at least a 150-bed unit for the acute, the mentally ill in the Greater Winnipeg area.

So, in short, we need more psychiatrists. We have eight on bursary now under our training program in addition to what you see in the estimates -- this is the program we started a few years ago, two years ago, where we have four, five psychiatrists in each of four years, in training. They spend two of their years in the department when they come on salary and the other two years at the Children's Hospital and at some other centre, in a teaching hospital. So we need more; we need all we can get. We're not unique here; they're needed all over. Our Child's Guidance Clinic is bulging; the Community Mental Health is popular, and I would say that in the Department of Health, the most exciting -- it's exciting to sit where I am as Minister at this time in the evolution of health services, to see the wonderful story that's going to be told in mental illness and tuberculosis.

I would say that with modern care treatment that where it took three beds to treat a patient by custodial methods, it takes one bed by present treatment methods, and I think we have every hope of looking forward to a great future. With tuberculosis there were 250,000 days of care -- 234,000 days of care in 1949 for tuberculosis. This year you are budgeting for 60,000 days -- this tremendous decrease in treatment -- and I would hope, it would be nice to eliminate most of those beds by Manitoba's 100th anniversary. Today, now that the Sanatorium at St. Boniface has been converted to chronic care and the care of our exceptional children, who will need medical care, the TB facilities are now centralized at Ninette, around 160 beds I believe, and we have just opened 64 beds in the Rehabilitation Hospital where we have our new Central Tuberculosis Clinic adjacent to that facility. So right now there are 191 chronic beds have been fully opened at St. Boniface San in addition to the St. Amant section.

I think that when we think of this, who would have thought of this, say 15 years ago, that we would be able to convert our facilities from one function to another. And we are on the edge of still more exciting breakthroughs as medical science advances, so I think we have a great deal to be optimistic and hopeful about. And we must remember that in tuberculosis and these other diseases that it is the day-to-day vigilance that our department maintains and the Sanatorium Board maintains in tracing down contacts and in stamping out new problems. There were only 56 cases, I believe, of tuberculosis recognized in the past year in the province in all their studies.

In the area of cancer, the cancer facility which will cost close to $2 million is going forward and we hope it will open up probably this fall, and it has in the past year been declared a facility for in-patient care under the Manitoba Hospital Services Plan in order to involve more federal participation. The foundation, in addition to creating this new building are monitoring and looking

(Mr. Johnson (Gimli), cont'd) ..... at all our X-ray installations in the Province of Manitoba for safety. A monitoring service. I'd hoped to have legislation prepared this year in this matter, but as the job is being done anyway in Manitoba at the present time, and as we're waiting for the development of a national code, re the handling of isotopes and other highly radioactive materials, the Advisory Committee suggested we delay this until next year. The new staff for this cancer facility will be reflected again in your estimates and this will mean more treatment both in and out patients at this service. I think the House is aware that now as of last year a tissue biopsy service is available throughout the Province of Manitoba, not only in a doctor's -- not only in country hospitals and in hospitals in Winnipeg but we've extended this to the doctor's office. It didn't seem fair that the doctor in the country could get his biopsy work done by sending it into the lab and the city physician could not. We rectified this matter.

There's one very new service which is going into effect, which I would like to announce at this time, is the matter which we have held up for a year pending further study, but is going to be a tremendous boon to the women of Manitoba, is a cervical biopsy service. A lot of work has been done on this subject in Winnipeg and the experts advise me that by preventative testing in the womb cancer, cancer of the cervix can be virtually eliminated if the women would submit themselves to yearly testing, and this is a very simple test, can be carried out as an office procedure, and could be a boon, will be a boon to Manitoba.

Arrangements have just been completed between the hospital commissioner, the Foundation and the hospitals who will be carrying out the tests. It is something that will have to grow. More technicians each year will have to be trained. It's a heavy service, but I think this is the proper function of government to see its proper role in this area, and I'm very happy that the Foundation have seen fit to include this as one of our services which will be paid for through the Foundation, tissue biopsy service.

Lab and X-ray. A lot of work has gone on in the department in the past year with respect to laboratory and X-ray service. It has been decided in conjunction with the radiologists and pathologists who are now teaching lab and X-ray people in large hospitals, and our own people at Portage, and in our own lab and X-ray program that bringing them together it has been decided that along with the Commissioner of Hospitalization and Deputy Minister of Health in numerous meetings, it's been decided that all the didactics for all lab and X-ray training could be given through the new Technical Institute --where we could give the didactics to 75 people a year, that capacity, and for instance, the various hospitals pick their personnel, send them to the Tech School for their technical training and they get their practical training back in their own hospital. The purpose of this is to prevent the duplication in all our hospitals of expensive training facilities for this group. I think this is a real step forward and I'm most grateful to the professional people who have co-operated with the department and the committee in the Technical Institute in developing this program. We hope, as I said, to graduate 75 technicians per year in this setting.

Northern Health services continues to be of real value and we're very proud of this newest branch of the Department of Health. The leadership given, as the Member for Churchill said in his opening remarks, the leadership given by our director in that area and our sanitary staff who are experienced people, especially Mr. Williams, and they are giving a service which I think is unique in Canada, where we point out to the Royal Commission on Health Services that we think in the future that one jurisdiction will prevail in the north, one set of rules for all Manitobans in that area. We have split the north, as you know now, down about the Hudson Bay line, between federal and provincial, and giving the same services, and it is working out extremely well. Our estimates are necessarily up there; the director is keen on carrying forward his sanitation and health programs in that area and giving more and more personal service. He's not only treating people, he's preventing disease and we're very happy that last year not one single death was reported from gastroenteritis from the sources where 22 had occurred I think the year before that. I can't speak too highly of the dedication of these people. They're away from home, up to 180 days of the year, which isn't easy in any man's language, and they're doing it in the public interest.

In Rehabilitation, again the over-all, this year's estimates show that over '58-59 to the present time, this appropriation has almost -- it has doubled; it's $323,000 this year. The great increase you see here is due to the fact that in the past year the new technical vocational training

(Mr. Johnson (Gimli), cont'd) .... agreement will come into effect on the first of April. This is where Ottawa shares 50% in the rehabilitation of a person to job training, to employment, and this means that we can give these monies to the Society for Crippled Children and our other rehabilitation agencies to expand their programs in this area. I think the House, they've seen in the Royal Commission submission the tremendous benefits that Manitobans gain from this really modest program when you think of it in terms of total cost. The Director of Rehabilitation advises me that through these four major agencies last year 344 people were rehabilitated and are earning a total income of $630,000 in their salaries because of their rehabilitation. One hundred and ten, mind you, were not rehabilitated but I was very proud to read of the meetings in I think it was Banff last year, the various directors of rehabilitation in various provinces across Canada, wherein this rehab program begun in around '53 has now developed to the point where it is really the most -- it's unique in comprehensiveness. There's a minimum of duplication. The co-ordinator has got this happy balance brought about between the various voluntary agencies, using the person's own resources and using the resources of other agencies, using government resources, etc. brought about this real comprehensive and -- certainly, this department has been most busy in the past year pulling together the various organizations as they want to expand their programs, interpreting this to the department and other agencies, planning even psychiatirc and other rehabilitation facilities, the great challenge of pulling people together with respect to the opening of the Rehab Hospital, which has taken in its first patients on March 5th this year, a few days ago, and the out-patients to work out the kinks in their program there, and the working with the hospitals on home care programs, so there's a great deal of activity 24 hours a day in that area.

This fall you graduate your first Manitoba graduates in Physio and Occupational Therapy. I think there are 19 graduating this fall for the first time, and the Hospital Services Plan, we've recently signed an agreement with the federal government to include initially physio and occupational therapy as an insured service under the plan. Incidentally there is only one other province in Canada who has done this and that is Nova Scotia. We've done this to start with. They have agreed with us that we could have this initiated in the Rehabilitation Hospital, at the municipal hospitals, at the Assiniboine Hospital in Brandon where some very wonderful work is being done in physiotherapy and occupational therapy for the inmates of that hospital -- tremendous; and at Dauphin where we are opening our first, or will be second, chronic facility as per the Willard Report. We're going to start in those areas. So certainly I think that the House can look with some satisfaction, if they don't agree entirely, with the activities of the Health Department as they are becoming more and more involved in giving leadership, in giving care in addition to prevention, throughout the various regions of Manitoba, and this is the concept, this is the area where they do need support and understanding as the role of the Health Department, not only to maintain our preventative health services but to break out with new programs to be of some resource to the people at the local level.

Now with respect to one other matter in the Health Department. I would invite the House, Mr. Chairman, to visit with me before we break up, the Rehabilitation Hospital -- I'll extend an invitation later when we make arrangements -- I think you'll be most heartened by this. Secondly, I would like on April 10th, those who are able, to come and visit the Industrial Hygiene Laboratory in the Norquay Building. The staff would like to set up demonstrations, prepare -- I think the Public Health people are meeting about that time and we could use this occasion to permit the members to see the many tests that are carried out daily by our staff over there in testing all sorts of things, chemical analysis, air pollution studies, etcetera, and I think you would find it most interesting and I will extend that invitation again to remind honourable members, but the morning of April 10th would be the day that I would choose.

With respect to the Manitoba Hospital Services Plan, again this year through the tremendous co-operation of the municipalities, 178 municipalities have now guaranteed, have a guaranteeing arrangement, and it works to mutual advantage to a great degree and also means that 99 percent of Manitobans continue to be insured under this plan. The annual report which I tabled earlier, the estimates for this year show that the $1.9 million surplus predicted a year ago in the financial estimates of '61 to '63 which we discussed in Public Accounts, has almost come out on the nose. It's almost a little too accurate the way it appears in the annual report, but these are the facts.

(Mr. Johnson (Gimli), cont'd)

I would like at this time to tell the House the second great activity under the hospital plan this year, besides the continuing studies re central laundry, group purchasing of all these things that the Plan are trying to get on with in addition to their day to day activities. In addition to what I have mentioned, the working out arrangements for our cervical biopsy service to be included; our physio and occupational services to come under the plan; the wide list of continuing review with medical and other technical committees of our out-patient procedures; the work they have done in translating legislation; the work they have done in bringing all these facilities from the Sanatorium Board under the Plan. The big study was the study of the Willard Report, or the Manitoba Hospital Board Survey, and I will be tabling tomorrow afternoon, I hope, the interpretation, the summary of the recommendations which we have come up with. By and large we endorse the recommendations of the Willard and Manitoba Hospital Board survey which was predicated to be carried out over a period of five years by Dr. Willard, although he did point out that if sufficient funds were not available to carry out this in a shorter period, or in that period, it might have to be extended. In implementing this we have said we have had something like $15 million worth of construction approved in the past two and three years on which we're still paying grants, grant monies which are allocated to us, as you know, on a matching basis by the federal authority. In addition to this we had to add our mental health needs and other projects, such as the Cancer Treatment and Research Foundation project, to the recommendations which Dr. Willard visualized as being implemented in this period. In addition to this we felt that the priorities really lay in making our breakout in mental health because of the fact that it seems to be ready to really be exploited in this area; that we should create these mental health facilities as we visualized, that we should try and get on with the job as visualized by Dr. Willard of developing as pilot projects immediately three or four chronic facilities adjacent to acute hospitals at key points in the Province of Manitoba. He mentioned Dauphin, Morden and Steinbach. I would say to you that Morden is already in operation. We formed a chronic care committee, advisory to the hospital plan, and are using the geriatric and other know-how of the doctors at the municipal hospitals and the Sanatorium Board in carrying out the type of program that Willard visualizes in the Morden facility. This has started already. We hope to have this go ahead at Dauphin and Steinbach.

So we said, besides mental health chronic care must be shored up, so we divided the report into those projects which were underway; (2) those projects where Dr. Willard said you have an emergency -- the roof's falling in; unless you do something here, times awasting -- money is being wasted. That took care of six of the recommendations of Dr. Willard. We felt that we would waste a whole year's construction unless we called in these people where emergencies had been recommended and those projects which were held up because of the fact that these people waited until the Willard Report came in before they proceeded with projects which the Health Services Advisory Commission had approved before the plan started, such as McCreary and Gilbert Plains. So we set the projects under way; we're going ahead with the emergencies we'll have in these hospital boards; we've talked over their problems with them. Where they concurred we took the problem to the Hospital Service Advisory Commission, talked it over with them, and most of these people are in the drawing plan stages at the present time. We also felt that the next priority after emergencies and minor renovations which were of no great consequence, that we had to put in mental health facilities; next the chronic care facilities; thirdly projects -- new projects and projects involving additional beds and so on. And we have interpreted this report much as Dr. Willard has recommended as to when these projects should go forward. Having decided this we then called in or wrote letters to all the hospitals concerned. There may be one or two who have not yet received a letter from us because of studies we have had to pursue. We've written to these people and said, "As per the Willard Report, in view of the $59 million bill before this adminstration, in view of the fact that we feel we're willing to proceed on the basis of making $1.3 million available per year in construction grants, we can implement this program in seven or eight years. It is planned that your facility will proceed in year so and so. Will you please come in and talk to us?" I have met with most of these boards at this time and discussed the Willard Report with them, the reasons for our planning.

Now you may say to me, "How can you commit future governments or future jurisdictions?"

(Mr. Johnson (Gimli), cont'd) .... It is imperative that we plan from year to year, but it's imperative now that we plan looking eight or nine years ahead. (Interjection) Well I expect to build every ittle and tittle of them, Mr. Chairman, and my honourable friend can -- I'll be glad to invite him to the openings though, and I'm going to table tomorrow a copy of the -- the name of the hospital, a description of the project and the year that Willard said this should go forward. In addition to that you will see those projects which have been completed this year, Dauphin, Brandon, the Rehab -- you will see other little projects in there such as a little grant money placed aside for the Retarded Chilren's group and the Children's Home where I think we should offer some assistance in these areas under grants, and all this will be spelled out for you between the annual report and the material that I submit.

I found out that both Britain and other countries are looking ten years ahead. What we table isn't gospel. It's a blueprint to follow. I think every year we should consider our capital and current, but we must look ahead so that we don't overbuild in any particular area of concern, and that we have a masterly plan that gets us to a fixed objective, and this is what I intend to do tomorrow.

Now I would point out that -- of interest to this House, the emphasis we've given to the chronic care. The WillardReport as you know, recommended that we create as a pilot studies where these chronic care facilities are adjacent to the acute hospital in question, but where the administration and philosophy of this is, what I call geriatrically orientated, that is orientated along, not just a dumping ground for progressive care alone, but where the whole concept of care in that facility is one of getting the patient on his feet and back into the community. Steinbach has been -- as Willard recommended we should build about 65 beds in that area, I think it is, or 40 beds, the Morden facility which is now in operation and the Dauphin facility which should be ready later this year and that our concept of care and our pattern of care in this province should be one of developing our long-term facilities adjacent to acute hospitals in certain points as the need arises, in certain areas of the province, which both fosters a group practice, it fosters -- if it's placed under the same type of philosophy that we've developed at the municipal hospitals and we're hoping to develop in other chronic-care facilities -- that this is the pattern of care that Manitoba should follow. Also it's interesting that the Director of our Rehabilitation Hospital, Dr. Truelove has played an active part with our chronic-care committee and in the Morden facility where he has come out as an advisor and to the Sanatorium Board in their facilities.

..... Continued on next page

(Mr. Johnson, (Gimli), cont'd.) .....

I submit to this committee, Mr. Chairman, that if we don't have this concept of rehabilitation; if we don't have this concept of creating chronic care facilities, the alternative is to plan on the orderly development of 900,000 beds and we all crawl in and occupy one. Therefore I feel very strongly -- which I'll come to a little later on to -- the need for this type of phasing of our program. Our aims in hospital, Mr. Chairman, must be to achieve improved public understanding of the higher cost of better hospital care. It's high cost care, but as I said earlier where three beds were needed in the hospital to maintain three patients, with modern, proper understanding and facilities we should be able to with one bed do the job. (2) To obtain through regionalization a more effective approach to planning and operation of all hospitals by voluntary and government agencies. We must regionalize to a degree to get the maximum benefits from our programs and to integrate the concept and practice of rehabilitation as a component of adequate care, and I think with the opening of our rehabilitation hospital, our first graduates this fall, that we're on the right track here. I think we have to have this dynamic program for our aged; that is the modern philosophy; and to maintain our standards in these institutions within a level that is adequate and yet not superfluous, and we must integrate psychiatric services into our General Hospitals as I've said earlier. And we must increase the availability of benefits to people who are ambulatory, people who don't want to be put into bed and laid down, who would like to be on their feet; and again our rehabilitation agencies and rehabilitation concept and the resources under The Social Allowance Act is an instrument in assisting many in need in this area. We always will foster a tendency to group practice in rural areas and in the long run possibly better and more comprehensive medical care. The home-care concept has to be developed, but none of these by itself is an answer; you have to go forward on all fronts together, home care; chronic-care; mental health. The challenge is not to bog down or to get carried with any particular concept that you may have. We must keep up-to-date in hospital planning and we have suggested to the Royal Commission that the federal government must get more and more involved in planning hospital construction if they are going to give realistic grants to the provinces. We must continue our education program; only by maintaining it and carrying it forward will we maintain the role of preventative medicine.

I think, Mr. Chairman, that one of our important problems is to keep hospital services in a proper relationship to health services as a whole and not to allow the one aspect of health care such as hospitalization, to devour a disproportionate cost to the health dollar. What I am referring to is we must be careful that the hospital plan and beds, per se, don't become the cancer in the health field that devours our money to the extent that we can't break out and carry forward active programs. It's self-evident I think to all of us that prevention should remain the central theme of our health program since it is of greater advantage to keep people well than to attempt to cure them after they become ill. It's not only humanitarian; it's good economics.

Now I think I would just like to make reference to the Royal Commission Report which you have all received a copy of, which largely in that section on the various activities of our department I tried to point out on behalf of the Province of Manitoba what has gone on in the past roughly, as short as possible, what is the present situation, and what we conceive as a program for the future. I think that we have to develop to the maximum those programs that we have now embarked upon and shore these programs up before we get involved in total new programs that may be contemplated. Especially did we plead for the inclusion of tuberculosis and mental care under The Hospital Insurance Act, and we indicated to them the fact that we have had a comprehensive survey of our health facilities. We gave the total figures as to what it might cost the province if we match 1.2 or 1.3 million dollars a year -- what it means in total cost to carry forward the recommendations that are before us now. The experience we have had in the development of hostels throughout the province; the Social Allowances Act as an instrument to keep people out of hospital. We reviewed all this, and we suggested that there be more realistic grants, we must have that looked at. These grants haven't really changed since 1948 -- they've become more flexible mind you, only four of them are now matching grants, where we must match Ottawa. We pleaded for instance that the medical rehabilitation grant have the ceiling removed, this is the grant that is of such tremendous help to us in rehabilitation and in offering our comprehensive rehabilitation program to Manitoba. We would like to see it patterned after the Technical Vocational Agreement where really there is no ceiling on a 50% sharing program.

(Mr. Johnson, (Gimli), cont'd.) ..... In short in the Royal Commission we said; "Let's shore up; let's do a job in the area we're in now. Let's create these facilities as a base line and a must before we get into some new program that prevents us from implementing a proper health program for the Province of Manitoba."

Mr. Chairman, that pretty well, I hope, covers the beginning of my introduction to my estimates, but I did want to take this opportunity to talk about some impressions on health services which I observed this past year when I had the opportunity to visit and see first hand some of the problems facing other jurisdictions as Britain and Norway. Now I want to make it very clear at the beginning, I think it's important to stress that my trip to Britain was not for the purpose of carrying out a survey on total health services. I am not an economist. I had read, I am sure as most of you have, the many conflicting articles coming out of these countries by various authorities. For every one I read praising, I read one that is the opposite. I think we're all aware of the foment which exists in Canada regarding the manner in which medical care services should be provided. And I think that as a rural physician prior to coming into this office, I think I had some idea of the examples of the situations that are used to both substantiate the need for and to substantiate the dangers inherent in any change from the traditional manner in which medical care is provided today. Now despite the fact that my area, for instance, like many of the members here, is a progressive community in Manitoba, we have our share of the low income families, and families that all of you know in many cases cannot budget for major medical expenses. Side by side we see the fierce pride and independence of our forebearers and neighbours who in many cases don't want any part of a scheme that limits their ability to seek out the type of care or the physician and other things of their choice. It was in this atmosphere, I think personally, that I developed my strong convictions about what I have referred to in this House as second-class citizens, and it was here that I felt that to a degree medical care benefits must be modified, or arrangements must be modified, to preserve if possible the convictions as well as the need of the two extremes that I've indicated. For example, I could never understand why, in the year 1962, that anyone said that the teaching of medicine should be dependent on the amount of poverty in the country. I think this type of thinking in some quarters always bothered me, although I don't think it's too widespread in this age.

Now since being in office of course I have been continuously aware that many of the statesmen of Manitoba, or the community leaders, assure my conviction that government must provide the leadership that will bring about changes in the organization of medical care to meet specific Manitoba requirements; and while recognizing this, I think most men are convinced that any changes must be soundly conceived and not simply the blanket replacement of what exists by something new that might be based on a series of quite impossible promises, and mixed into this there is another complicated ingredient.

I have been told, and you have been told that all we have to do is emulate the National Health Service of Great Britain, or that we should take our guidance from the health services of Norway or Sweden. And while I've always had great respect for Scandinavian and British schemes that I had read about, too frequently I was stumped by an inability to understand why it is possible to do these things in these countries that would be difficult or well nigh impossible here in Canada or Manitoba. I wondered often, is it the people, is it the doctor, is there a different political climate, is the tax base different? These and many similar questions occur and re-occur each time I use the examples provided by these services, and therefore I was quite thrilled when my colleagues suggested that I should take a very rapid trip to England and see for myself. And I want to reiterate it wasn't a formal survey, I wanted to go there to observe the people, the places and the doctors or the physicians and I thought maybe if I was lucky, even the politicians, in an attempt to draw out some of the strong and weak features of the health services, and more particularly to observe the kind of people that were involved.

I made arrangements with the British Ministry to spend a few days there and I also was very kindly accommodated by them in meeting the head of their health services, Dr. Davies and the leader of their psychiatric services, Mr. Phillipson, and some of the technical people dealing with laundry services, drugs and so on. Not knowing London, they're all in different buildings, they're not consolidated like they are here, and I spent a fair part of the day running around to different appointments by taxi, which I had to use because I didn't know my way around. Then the British Medical Association were very good in that -- I only was there 10 or 11 days --

(Mr. Johnson, (Gimli), cont'd.) ..... they brought in people, they brought in a public health official, a man in charge of a region of 4 1/2 million people; they brought in a general practitioner from, as we would call it, the grass roots level, or small town. They didn't bring in too many specialists -- maybe they thought I couldn't confer too much with them. I did meet some specialists and experts in these different fields and visited the BMA House which is the seat of their learning. They were very wonderful to me in mapping out a program for the ten days.

I wanted to just tell the House some of the thoughts I had; I think I probably have to earn my keep during that short jaunt. I hope I was able to learn something that would be of benefit to us. Mr. Chairman, I found you had to temper the reaction of the man on the street, it's important to temper this by the fact -- only about ten in a hundred people really are sick enough during the year to require admission to hospital. You double that figure and let's say 20 people out of each 100 make use of the national health scheme for a serious medical situation in any given year. When you ask the man in the street -- and I did go into some places where I could talk to them -- (Interjection) -- I always think of my Honourable Leader of the CCF when I see that material, if you know what I'm talking about -- what do you think of the national health service, four out of five will say: "Thank God I didn't have to use it for anything serious." "I think it is a wonderful insurance scheme" they said. "It has dispelled all my concern over the cost of catastrophic care." "I know it is costly but I couldn't be without it." This is what the reaction was from the majority of people that I ran into. We found the reaction of one in five that had had to use the service for an emergency or a major situation was quite different. Time and again we heard complaints of the crowded offices, the hospital waiting lists, the disappearance of the family doctor. In discussing with the Chief at the Ministry, Dr. Davies, I was very interested because he was working on a paper called "The Waiting List", and he described the waiting list as a very necessary part of hospitalization for many reasons. He said that obviously everybody that can wait shouldn't have come in at once; no government, no service could develop enough beds to accommodate everybody to meet their particular situation when they wanted to meet it. It's the same as -- they compared this to hotels and so on, but the one thing I thought was quite amusing was he said: "As a matter of fact I think that the waiting list serves its greatest purpose in that it delays the assault on the patient and by the time they come in they're pretty well ready to go home again." --(Interjection) -- Oh no, these things just happen over there.

The man on the street however, is only a small part of, he's not just small, he's part of the story, and at the Ministry I think we were reminded of the first basic difference. Both London and Oslo, where I visited later, are the centres from which the British and Norwegian Health Services emanate out to cover the whole country. Geography and political structures combine to encourage a highly centralized operation. Although considerable decentralization has been called for, both ministries are heavily involved in guiding policy and fiscal controls. Each of Britain's 15 regions, composed of approximately 3 1/2 to 4 million people, submits its estimates to the Central Ministry, and until recently there had been a ten-year freeze, or ten-year, almost a freeze, upon the creation of new hospital beds. Hospital construction and reconstruction at the present time is receiving a great deal of attention. And all hospitals under the health service are what we call in this country "closed hospitals". Each has its own full time and consulting staff and each serves an area from which the general practitioners admit their patients. Unlike this country the general practitioner has no responsibility for, or contact with the patient once in the hospital. Whereas Canada has a few closed hospitals, notably University hospitals or parts of our two-three major hospitals in Winnipeg, they do have teaching wards and these are the only closed wards for medical care we have. In Britain these closed hospitals, universities, serve the metropolitan area. Of course in this country our scattered population puts more reliance on the versatile general practitioner making proper use of local facilities than in these large metro areas.

Dr. Davies in the British Ministry advised me that of the 15 regions, each one of these regions has a voluntary board. These are voluntary people donating their time, outstanding citizens in this region -- these regions of 3 1/2 to 4 million people. In these regions there is a full-time administrative officer who submits the budgets to the hospitals in that region and there's a central supplies officer who is charged with trying to bring about more centralization of laundry services, for example, group purchasing of drugs, and the regional head sends his

(Mr. Johnson, (Gimli), cont'd.) ..... budget in to the Ministry. And for several years now the Ministry in allowable expenses just said 2 1/2% per year, that's what you get, and the Ministry doesn't become involved with the detail of every ittle and tittle of work that's going on in the region; they just tell the region how much money is available this year and it's been averaging 2 1/2% per year for some time. Now the regional boards are also charged, and I think this is a good thing, with creating the housing and hospital type of accommodation for other than in their region. The Ministry is just concerned with over-all planning, the type of philosphy, but a great deal of emphasis is placed on individuals to get programs going and the Ministry isn't involved in the day-to-day activities.

There's much leeway therefore at the local level and the amount of voluntary participation in running these regional boards is very high and it's a very good thing.

The one thing I must tell the House, I have been concerned, concerning the future training of doctors in closed and open hospitals, which is before our teaching commission, as you know, so I went to see a teaching hospital because all these regional hospitals submit their budgets to the Minister and he adds 2 1/2% and sends it back. I thought the Leader of the Opposition would appreciate that. Each year it just goes back to the regional board and they divvy out to their hospitals as to how far they can go each year. The teaching hospitals, however, send their budgets direct to the minister. I went into St. Thomas' Hospital, which is across Westminster Bridge from the heart of London -- St. Thomas' as you know is where Florence Nightingale started her work and is one of Britain's famous teaching hospitals. When I arrived in the morning early, there must have been one to two hundred people lined up in the out-patient department waiting to receive either medical consultation or their drugs -- they queue -- they were queued in the out-patients department. I spoke to the Dean of Medicine who had a very small office in the middle of the first floor, and after talking to him he thought it was more important for me to talk to the administrator and I was ushered into a very large room with red panelling and red carpet. It was 9 o'clock in the morning and my friend asked me: "Sherry?" I thought, my gosh not this morning, and I'd like to ask some questions, I said. "How long have you been a closed hospital?" "Closed, my boy," he said, "we've been closed since Magna Carta." That set me back on my heels somewhat and I said, "Well you submit your budgets direct to the minister. What does the minister do?" He says, "My boy, what can the minister do?" He says, "We've been setting budgets for 800 years." So you can see there's a great deal of tradition and precedent for their services in that country -- and again they were most hospitable. St. Thomas, incidentally was bombed badly during the blitz and is one, being a teaching hospital, is one of the first to be reconstructed and they were building the new structures when I was there. However, I must say as a Manitoban and as the first look in going through these facilities, their facilities are certainly facilities which many of our personnel, I think, would work in reluctantly. I am not being critical of Britain in saying this but I do -- I am convinced, and it's obvious that the tremendous expenditures in operating all these facilities and hospitals and in meeting the medical care expenses have prevented them from breaking out into newer concepts of care. But on the other hand, it is absolutely wonderful the things and programs which have been developed by these people when they didn't have a lot of money for bricks and mortar. They converted old residences and did so much, developed programs, which is a lesson to us in that we should develop programs before you start building to meet a need. The investment in staff and personnel comes first. There's a lot to be learned and I am going to tell you about it.

The care of the old and the frail in England and the chronic sick as I pointed out is a responsibility of the local authority at this regional level. For many years local authorities have operated huge old folks' homes, and until recently these have been tragic institutions. Just outside of Oxford we spent a day -- I spent a day with Dr. Lionel Cousins who is at a place called the Colley Road Hospital and is one of the pioneers in helping Britain develop a new look at the care and support of the frail aged. Dr. Cousins by the way came to Winnipeg and helped us in Manitoba and was one of the consultants to the Manitoba Hospital Survey Board and a very strong believer in activity -- activity on the part of the patient and on the part of the medical staff. Inactivity, neglect and ignorance of day-to-day medical conditions in the past combined to cause many old people to become full-time bed patients. As we visited Colley Road only three or four of the 180 had to be served their lunch in bed. By intensive work-up, encouragement, mental and physical stimulating activity, Dr. Cousins strives to rescue simple competence.

(Mr. Johnson, (Gimli), cont'd.) ..... His patients are then returned to the community with follow-up services, and this sort of personal attention of the ambulent, and there's easy re-admission in case they become ill or to relieve the family of the burden for a period and let then get away, for example, on a holiday, and by supporting out-patient services and other hospital facilities. What is the result of this, and gentlemen I think this is the key, the lesson I learned at Oxford -- he can say that each bed in his hospital is supporting three beds in the community. In other words where neglect and the old schemes required four beds, Dr. Cousins is getting along with one bed, and this was most interesting. The accommodations he had to work in were built over the old poor houses that existed — he had one of them where he was sent with a bit of money and his ideas and he was told when he came there that he could expand from 250 or something to 350 beds, and he's down to 160 beds. He has this activity and this orientated -- this program which you can only say is exciting. For instance on the first day -- and he's dealing with all ages -- on the first day a person coming in bedfast 100% say, by the 90th day, 31% are bedfast, and after 180 days in his institution 1.5% are bedfast. In other words, the whole philosophy is in getting them up. It taught me a lesson. It's his staff who see his results who make his scheme work. I wouldn't want to lay down with that nursing sister there. She would -- Well now ..... I sure walked into that one. I'll get off the subject. -- (Interjection) -- Well I didn't have time to give anyone a break there, but the ..... highlight of the trip was a trip arranged by the Ministry of Health for a full day at a -- I wanted to see a huge mental hospital on the south edge of -- in England.

The day I arrived or was in that country, the Minister of Health there, I think it's Sir Enoch Powell had made a statement that within 15 years he would cut his mental hospital down by three-quarters or some very large figure. The Minister of Health suggested that I spend a a day at this institution, and it was a typical aggregation of old brick buildings and on a 500 acre estate. I used to think Brandon and Portage or Selkirk were large. Heavens, this was like putting four Gimlis together in area and it resembled -- everything resembled very much our old mental hospitals that I have referred to as our battleships. Inside this facility of this, Dr. F..... who is now I believe, head of the mental health service to the British Ministry -- the whole atmosphere was a thrilling one, emulating precisely what our provincial psychiatrists and staff hope to bring about in Manitoba. The old building was very gay and lots of colour and rather than being an island unto itself, the activity of this hospital has involved more and more community services and elements. Within the one building, for instance, we visited three areas where occupational therapy was flourishing at three different levels. The tasks that were carried out varied all the way from assembling single wires into cables for television sets to the scavengering of wires, nuts and bolts for telephone equipment declared obsolete by the post office, from this telephone equipment. Each week the superintendent spends a large part of the day at an in-service training period with his public health nurses, etcetera, and every effort is utilized to return the patient to the community to support him there with out-patient and similar services. And along with the superintendent we visited his day hospital. Now all he did was go downtown into the community adjacent to his huge institution and rented an old house, an old brick house, where he had a couple of psychiatric social -- no, I think he had one psychiatric social worker and two occupational therapists. These people are encouraged to go to the day hospital and there receive their daily -- some of them were carrying out occupational therapy procedures and doing things with their hands or reading and so on -- and there he gives them his medications. I spent an hour or two in that facility with him and went around to -- here were even young mothers with their babies in carriages and leaving the carriage outside. He laid on baby-sitting services while he treated the mother. The alternative was hospitalization, and the hospital is simply, in this case, an old residence, this day hospital as I said, an old residence in the community. Britain, they are very determined not to build any more large mental hospitals as I have indicated.

It might be interesting to note that the number of beds per thousand for mental illness in Britain of 3.3 is roughly the same as our own. They're also working toward integrating their mental hospital into their general hospital beds, and during our stay there, there was a conference on this matter at Maudsley Hospital and it was discussed there that in the future the average British general hospital they hoped would be six to eight hundred beds with a maximum of 100 beds as a mental health facility adjacent to it; and they predict less beds, with more staff, more

(Mr. Johnson, (Gimli), cont'd.) ..... treatment, less beds, and they're determined to go after this.

Back in London I also had the opportunity of spending a day at a rehabilitation centre where the program being carried out is what we anticipate will be carried out in Manitoba. There in almost deplorable conditions, in an old building, one doctor had 100 patients, and I would hope to see -- the conditions under which he worked and the results he was achieving was certainly remarkable. Old people were coming there when I was there, and one old fellow would say, "Joe, I come three days a week; how often are you coming?" and these people who'd had strokes, who instead of being in bed are up and around and they look forward to their day at the rehab facility where he has then doing exercises, playing games and it was almost like a glorified baby-sitting agency for old people, but it was good medical care they were getting and this is proving very popular and certainly it keeps people at home.

While in Britain I was anxious to learn all I could about the role of the Health Officer and the role of his office -- what we call a health unit here. Britain's health services have always been very strong and adaptable to rapidly changing conditions, and the development of the National Health Services placed much heavier responsibility on local health departments for the support of the elderly, the chronic sick and the vastly increased numbers of discharges from mental hospitals. More and more the health officer is becoming what I referred regarding our own health officers in our brief to the Royal Commission on Health, as co-ordinators of sickness prevention, care and rehabilitation services. This is what they should be at the local level. With the co-operation and help of the British Medical Association, we discussed these trends with the recent president of the Health Officers Association of Britain. From him we confirmed directly how very similar our problems really are. Like Britain, Manitoba's health units are adapting to the new role made necessary, particularly by the hospital plan and the increasing discharge potential of our mental hospitals. Like Britain, Manitoba must be able to attract and retain keen doctors in the public service and we must be willing to complement their training and reset their sight by allowing them to see how programs are going on elsewhere.

I have already referred briefly to the fundamental difference that exists between the role of the general practitioner in our two countries. In Britain each hospital is fully staffed by doctors and the GP refers to them all patients requiring care. In Britain the general practitioner does not, as he does in Canada, attend his patient in the hospital. There is in Britain a tendency for the GP's office to become a mill, processing large numbers of patients for admission to hospital. We learned that both the British Medical and the Ministry of Health are concerned with the long term effects of this trend. General practitioners for instance received during '59, 10¢ of the NHS dollar and hospitals 64. The British GP's ..... as a consequence require to process on any given day, numbers of patients as could stagger his colleague in Canada. In most instances tests as we know them are not available outside the hospital.

Now in saying these things, despite what you hear in talking to this head of the Public Health Service and with a general practitioner at the local level, who I spent luncheon with, the biggest single failure admitted to me, and which I could see, was the mistake of not creating at the local level those lab and x-ray and diagnostic facilities which help the local physician to keep the patient out of the hospital. They haven't got around to developing them and the practitioners find -- expecially a general practitioner who never takes a patient into the hospital, is lacking in these diagnostic skills and help that he needs to do a more exciting medical job and a better job within his own practice. This is something that is basic before -- this is what we've said in our Royal Commission brief -- this is something they regret and they don't know how they'll ever catch up. This is the thing we should shore up in this province before we introduce large costly schemes.

It was also interesting that while I was there, there was a conference held in Edinburgh where 15 nations met with the medical director of Norway, Dr. ..... and leaders in this teaching field, met to discuss how do we bring the general practitioner back into the hospital. This was the whole theme of their conference. And as I will describe later, in these countries even now the public health officer is a co-ordinator of sickness, care and what not and has a lot of prestige in the community, whereas the general practitioner without the diagnostic aids tends to become discouraged in the heavy panel practice where he hasn't got the academic brush off of his colleagues, and it leads me to say that -- Britain of course has had this experience for

(Mr. Johnson, (Gimli), cont'd.) ..... 40 years and since sickness insurance on the panel basis has been available to breadwinners since 1918, and I would say categorically that Canadians would not, or Manitobans certainly wouldn't tolerate the type of service in this case. Canada itself, because of its widely scattered population alone, could not organize its services on the British pattern -- medical care services.

As I indicated at the outset it wasn't a trip to conduct a formal survey. In Britain I developed very considerable respect for the British National Health scheme and I would say that it could only happen and only succeed in Britain along the lines that I saw. Whereas Canada can learn much from their medical, socialogical and economic experiences, we must devise our own way of tackling our own problems in our province. Having visited Britain and the High Commissioner's Office in London, they suggested very strongly that I should spend a few days in Norway and accordingly I was able to spend four days in Oslo and many of you know that the Norwegian scheme of medical care has been widely publicized and acclaimed. In Norway I felt very much at home. It's a country much like our own, it has a low density of population inhabiting a rugged terrain. What is more the level of living is much like that which you and I know throughout Manitoba. Unlike our country, these people have been living together for thousands of years; they really are more mature it seemed and probably more national pride was evident. I would add, Mr. Chairman, that they've achieved all this despite the withdrawal of the cream of their aristocracy and their beautiful women about a thousand years ago.

In Norway, I did have the privilege of spending two days with Mr. F..... Alexander. Mr. Alexander was a co-author of a book on the social services of the Scandinavian countries, a copy of which I have, and has been in this field for many years -- very knowledgeable, played a role in setting up the Swedish plan and it was delightful to talk to him in an informal way as to enunciating the problem as we see it here in Manitoba, and the state of evolution of our services, and asking him direct questions and having him offer some advice. Since 1956 the entire population of Norway has been included under compulsory national health insurance. They started out with the present scheme in 1911 and finally extended this to the whole country only in 1956. Actually he said they had been at it for close to 200 years and gradually evolving their present pattern. Bit by bit they built this social system up. The central government, as I say, started this, the plan really began in 1911 when a law establishing compulsory health insurance for workers whose income was below a certain level.

Norway's current program, unlike that in Britain does not pay the full cost of medical care. For all, except a few, the patient must himself pay part of the fee. The care of the sick is, of course, highly developed and no direct charge is made for treatment, care, lab tests, medicine, food; but like Britain each hospital has its own medical staff so that the general practitioner again does not care for the patient in the hospital. They have demonstrated how deeply a government must become involved to control for instance the rising cost of drugs. Whereas all drugs in hospital are supplied, as they are here, free, all but to the sufferers of certain dangerous diseases who must purchase their own drugs. The drug industry is wholely state controlled. The National Government decides where and when a new pharmacy may be opened and controls retail prices. Whereas tens of thousands of pharmaceutical products are available in Canada, Norway has succeeded in holding down the number of registered drugs in preparations to about 1,600. Despite all this, it is interesting to know that in both Norway and Britain the cost of the services of all doctors in practice is almost exactly the same as the cost of drugs and medication. It is obvious that Norway has made giant strides in the provision of medical care by the use of giant measures, and I might add the application of giant tax structure. Their experience should be of great value to us and the newer countries of the world.

Under the Norwegian plan, which is compulsory, the employer receives, under the health insurance benefits, both payment in kind or cash. The employee receives services in kind. Everyone must pay 60% of the first two house and office calls. They find that this helps with total cost and prevents abuse in their plan. But after the second call which they think of as a deterrent to prevent a chap shopping around, they consider him really sick and they pay the whole thing. But it was most interesting over this long period of time this has developed. Everyone must subscribe to this, of course. The interesting thing that I would share with the committee, Mr. Chairman, was both here and in Britain there are many people who claim that, just like having a horse in Manitoba, they like to have their own doctor -- it's not a horse I'm

(Mr. Johnson, (Gimli), cont'd.) ..... thinking of -- like having a riding pony over there, if you're anybody you have your own physician. There is quite a difference in the structure of society which made me feel that while there was much to learn from their medical care plan, we are a pretty ultra-democratic society in this country compared to some of our older nations.

One aspect of the Norwegian scheme of course with reference to my department is the tremendous development of the public health services. The health officer in Norway is a highly regarded important individual; like his cofrere in Canada he is responsible to a local Board of Health for a wide variety of services besides his traditional public health program. He supervises all medical institutions in his district, all mental patients and out-patient care, he controls local rehabilitation programs, the co-ordination of local programs and voluntary agencies. I believe that we in Manitoba can learn a lot from the mature public health program, they have perfected this on a regional basis and these public health officials have a great deal of respect and prestige in the community and it should be emulated and I would advise the committee, Mr. Chairman, that I have a copy of a book which I have placed in the library, "The Health Services in Norway", where many of the members can go and read it, or get a copy from myself if they wish to read a very wonderful story.

Well, I have just about exhausted your patience and the patience of the committee, I am sure, in reviewing some of the areas and impressions I had of this "junket" of mine, but I do feel that -- in short, I had the feeling that it's most important to retain an element of personal responsibility in anything we do in the future in this province in extending medical care. And we must keep some responsibility at the local level and you see this really in Britain, to a high degree, and in Norway. They have 736 what they call municipalities in Norway, and these agencies collect the premiums, they collect the medical care premium and the hospital premium at the local level, and these are very powerful, both politically and every other way. They're integrated little units. They have a lot of pride in their programs. But then you come to the hospital and every hospital buys its professional care. The general practitioners do not deliver babies in Norway -- they're not allowed in the case room. The hospital, of course, uses midwives and calls in a hospital consultant. And this is very, very important to realize in Canada that we have the type of country with distance and diversified population and so on and the type of practitioner who is quite versatile at the local level. There's a great deal of control in costs in the British system and the Norwegian system that you have not got here. When I was there 50% of the interns and registrars or senior medical personnel in the hospitals of Britain are from the Far East. This is a high figure; there are 22,000 doctors in Britain; they have 50 million people and they're short of doctors. The Willason survey they had which predicted enough doctors, which they held in 1951, has not proved true. In this country we're already facing a drying up of the source of immigrant doctors that we've had from Britain in the past ten years into Manitoba. But for the doctors we've had from Britain, Manitobans would not have the health services we have in Manitoba today. These men who want to specialize in British medicine after graduation have to stick around until the boss is 65 before they can take over in the specialty and some of them get a little tired waiting around and they emigrate, and with a less supply coming up and the consultants getting older, these jobs are now being filled and Britain is facing a problem that is of some degree.

In Norway the medical education is completely state-sponsored and you don't leave there after you graduate -- you stay home. If there is an opening there you practice there. There's a great degree of state control in these areas. The lower income groups feel they can't be without medical care; it's a must for them because costs can be so high. Those who are well-to-do are willing to pay the basic premium as they feel it's a good thing for the country, but they like to have the freedom of seeking out their own services, and you must not overlook this -- this is what's happened both in Britain and Norway. This was my impression; I'm just giving it to you for what it's worth. But we must, in other words, temper our ideals with common sense. We mustn't give everybody a cadillac when a good standard chevy will do. I think that the lessons we can learn from Britain is: Let's not be too fast; let's shore up our diagnostic facilities before we make the same mistake as they made, and as the old doctor in Norway said: "Evolution not revolution is what will resolve your problem in Canada" and shore up where you can.

Well, Mr. Chairman, I think I've wandered all over heaven's half acre -- I'd be glad to

(Mr. Johnson, (Gimli), cont'd.) ..... answer any questions -- but I did want to, in addition to introducing the activities of the department, say a few words on the trip I had which I was very grateful for, and I hope it can be of service to the department in some way and the province in the future. Thank you.

MR. SHOEMAKER: Mr. Chairman, I wonder if you would be so considerate as to call it 5:30, because if I spoke one minute for every hour the Minister did it would be 5:30, and I would appreciate it very much if you would call it 5:30.

MR. ROBLIN: Mr. Chairman, I think that's a reasonable suggestion. We've heard a very lengthy statement and members are entitled to a little time to think it over. So I'd move that the committee rise.

MR. CHAIRMAN: Committee rise and report. Call in the Speaker. Mr. Speaker, the committee of supply has adopted a certain resolution and directed me to report the same and ask leave to sit again.

MR. W. G. MARTIN (St. Matthews): Mr. Speaker, I beg to move, seconded by the Honourable Member for Brandon, the report of the committee be received.

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

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

Mr. Speaker presented the motion and after a voice vote declared the motion carried and the House adjourned until 2:30 Thursday afternoon.