Donna Wilson

DW: My name's Donna Wilson and I'm a nurse, a registered nurse, and I also teach nursing at the University of Alberta. I'm a little bit unusual as well too because I still work as a nurse in the hospital. I have a full time job teaching and doing research but I still have the great pleasure of working in one of the big hospitals here in Edmonton as a bedside nurse. I don't really believe that the more education you get the less you want to move away from the bedside or that there's no interest. It's just fantastic to still keep my hand in. I happened to graduate with my PhD in 1993. About the day that I pressed print was the day that Ralph Klein, who was elected on the strategy of "he listens, we care" or "we listen we care," came in with major healthcare cuts and social services cuts and education cuts. If you remember, in those days everyone got a 5% rollback. Even the poorest people and the lowest-paid people that were public servants, government workers, all kinds of healthcare workers received a 5% wage rollback. Also the funding cutbacks, they were cut and cut and cut again. So people were laid off and then more people laid off and more people laid off. From '93 to '95 half of all of the hospital beds around the province closed. One out of every eight nurses in Alberta was permanently laid off. There was an enormous interest at that point in private healthcare, with the rationale that it would be cheaper if we had these private companies coming in. There was a great appetite for for-profit companies coming forward and saying, 'we'd like to offer a parallel healthcare system to the Canadian healthcare system,' like the Hotel De Health in Leduc. So here was an ironic situation that we've got a public hospital, a lovely new hospital that was built using public funds. There's not enough funding to keep it all open, so closing actual whole floors of that hospital, then a company coming in and saying, 'we'd like to use that and the operating rooms and we'd like to fly in Americans or maybe anybody who wants to come in and come and have state of the art healthcare'. Of course at that point it was very apparent that if there was a private customer that they would get dibs, they would go first into the operating rooms, get first dibs in the lab and all the rest of it. So, there were enormous challenges from '93 to '95 that became apparent with all the cost-cutting, the lack of planning. But the great interest in having the private for-profit sector moving in picking up where the public system couldn't manage or was said not to manage. So I happened to work with John Dossiter, who was an ethicist, and we formed a small group called Echo Ethics and the Crisis In Healthcare Organization. We were one of the first groups, because Friends of Medicare had sort of gone into hiatus for a period. We were one of the first groups to start calling media attention to big issues in healthcare for advocating for our healthcare system and also raising public awareness that there were other options than turning to the for-profit healthcare sector. Very soon after our group was formed, Friends of Medicare became active again. There was a huge rally, very well attended by all kinds of healthcare professionals, the public. It was one of those wonderful events where just everybody came together. It didn't matter if you were well educated or not, if you were a public servant or not, if you were a nurse or doctor of physiotherapist or whatever. By then there was enough awareness of the fact that everyone should be concerned that there was a major kickoff with the Friends of Medicare becoming active. Which was very good, because my little group, it really

needed a much more broad-based approach and people much more dedicated, full-time people working full-time on this issue to really get the news out, talk to people, go around the province, and really continue to raise awareness and really focus media attention and public attention on issues that the government had to attend to. The government couldn't just say, 'we have regionalized and now it's the regional health authorities that are the problem now.' It really was apparent it was still government that was driving the healthcare sector or system in Alberta. So Friends of Medicare came along in great force at a very important time. So that's kind of the history. I happened to have a period of time where the leader stepped down and I filled in for a few months. As the leader, this was mainly though after the huge cuts had happened and the bills that were of such concern – the Regional Health Authority Act, the Gimbel Foundation Act, and also Bill 31 – all of these were very pivotal points that Friends of Medicare were very involved in. Each one of those acts – the Regional Health Authority Act, which could have been really set up to promote for-profit healthcare in Alberta, the Gimbel Foundation Act, which would have made it very easy for a large for-profit company to come in and claim charitable tax status, so pay no income tax, a very interesting bill, and Bill 31, which would have really given the private for-profit sector a very open playing field in Alberta with almost no controls or checks or balances against them. So Friends of Medicare came along at a very good time with very good people, to really be quite reactive and in some ways proactive about these bills, looking at what these bills would have done if they would've been passed, and being very clever about speaking to the right people, getting media attention, getting information, sharing that information, and going around the province and raising awareness. So, enough people talked to their MLAs, enough people talked to the premier, enough people became concerned with not just the short-term impact but also the long-term impact of changing our healthcare system into basically an Americanized healthcare system. So, Friends of Medicare was really very instrumental in being there with these major proposed acts or bills that would've really allowed for-profit healthcare to flourish in Alberta with virtually no controls and also with no awareness of either the short-term impacts or the long-term impacts of them.

Q: Talk a bit about you taking over as the leader.

DW: When I came in, most of the big battles had been fought. It was kind of in a hiatus over a summer period where I just kind of filled in for a little while. During my time it was a very quiet time, because most of the big battles had been fought around the Gimbel Foundation Act, around Bill 31, and around Regional Health Authority. And Hotel De Health and a few other schemes that really needed to be thought out. This wasn't just a simple little company coming forward with an idea for how they would make money. There was much more at stake to that. So my time when I was a leader was just a very quiet kind of time. I think that's always been one of the challenges for Friends of Medicare, is that the public support and their willingness to fund a voluntary organization, Friends of Medicare, that support is much more apparent when there's some real challenges or issues and the government is worrying Albertans. Albertans then as individuals step forward and want to spend hours and hours of their time, and the other public that are willing to fund an organization like Friends of Medicare. So that's probably one of the biggest challenges. When you think of the fact though that we have

the Parkland Institute that also came along at the time that Friends of Medicare kind of was revamped in '93, '94 and '95, when Friends of Medicare really became very important for public healthcare, that also was when the Parkland Institute, when some leaders there realized, much like Friends of Medicare, that you needed to have stable funding, you needed to research, you needed to be proactive about issues, and you needed to be highly credible about issues as well too. So the Friends of Medicare came along about the same time with many of the same people promoting it as the group that started the Parkland Institute. When you think about this, it's almost like we've got two groups that are very much in stream. Friends of Medicare, which is very important whenever there are issues and that there's someone that the media can go to, there's a very credible group. But then there's the research arm, which is broader than just healthcare, but there's the Parkland Institute that also researches healthcare issues and researches other issues. So, the two of them are working very much in tandem. It's nice to see that. Alberta has over the years developed some very important organizations that are very important, especially when you think of the power that an institute like the Fraser Institute could have in Alberta with their research that is really not very advanced research, but they certainly seem to get a great deal of media attention. They're very well-funded, they obviously meet the needs of a certain group of people. But it's certainly not, in my view, the view or the research that supports the greater good, the public. So it's pretty clear in my view, having read almost all the research on public versus private healthcare, that a public healthcare system is the best system. What Friends of Medicare does then is very important work to be there whenever there's some kind of a challenge to this public healthcare system. The Friends of Medicare, the most wonderful thing about it is that it's there when it's needed.

Q: Why is the public healthcare system the best healthcare system?

DW: There's quite a number of reasons that I think a public healthcare system is better than a private healthcare system, or definitely better than a mixed private/public healthcare system like the American healthcare system. First of all, when everybody is dependent on one healthcare system and you know your tax dollars have gone into it, that means that the rich and the poor and the middle class all advocate for that healthcare system. They all have a stake in that healthcare system, it's their taxes, but it's also the place where they're going to be getting healthcare. When you have the wealthy and the middle class and the poor all needing healthcare and all depending on the same healthcare system, you can be sure that it's not a poor healthcare system. It's very evident that a poorly funded healthcare system is a poor system, and it's a system often only for the poor. So the Medicare and Medicaid programs done in the United States is a good example of that, of how it's the minimum of what can be provided. There's always concerns about whether the quality of the healthcare that's provided, the access to the people, but again a system for the poor is a poor system. Why wants to pay for it? It's like a charity. That's one of the main reasons for it as well too. But I think the fundamental reason why I think a publicly funded healthcare system is very important is it's extremely economical. We have a very good healthcare system where we don't have people, doctors or nurses or other healthcare providers, who feel a reason to try and encourage patients to have surgeries or tests that they don't need. That's very common in for-profit healthcare

systems or services. So down in the United States you never really know if you need that healthcare test or treatment or whatever, because it could be padding somebody's retirement fund. It could be padding the shareholders' money that they're getting out of this corporation. So those are the major reasons, I think. But there's also the fundamental thing as well too, is the issue that rich middle class and poor people all get sick and need healthcare. Canada, in their wisdom, over many years, even before Tommy Douglas came along and really set the system up, Canadians I think had compassion for poor people, for middle class people and even for rich people who became ill. It's evident that everybody does get sick periodically. Why should some people have better access to the healthcare system because they have more money or they have political ties or they have some advantage over someone else? That equality issue is also one of the big reasons why Canadians have set up this healthcare system and why Canadians are very much in favor of it. This is not just a small group of people who are in favor of a publicly funded healthcare system – this is the vast majority of Canadians. This is almost all Canadians that support this view of the healthcare system, that it's there when you need it and it's there for all people. It should treat people all the same.

Q: Did we win anything on each of those three acts that were in play when you got involved and when Friends of Medicare was involved in '93?

DW: All three of the above. With the Gimbel Foundation Act, it was stopped in its tracks. That bill was never passed. What it also did was bring together very different groups who recognized the challenges that that act would've brought forward, that for-profit healthcare could be a charity and pay no taxes and compete with other charities that are depending on donations. It challenged the universities, because not only would it be a hospital, the idea was it would be a hospital in Alberta, specifically Calgary, but they would also train their own doctors in that hospital, so it would be challenging the medical programs around the province. It also was very unusual as well too in that the board was a straight MD board. Here you had a charity with only doctors on the board who could vote and decide how much they would be paid for being on a board. This again was supposed to be a charity where they would be not making money, but yet they could vote themselves a million dollar annual salary for sitting on the board. So there were many people that came together that recognized the challenges of this, Friends of Medicare being one of them. I still remember sitting down in the Legislature when the bill was actually brought…the bill was actually brought forward three times in three different sessions. The first time, it was just basically tabled. The second time was when there was enormous opposition from all of the different groups that came forward. Even eye surgeons in Edmonton came forward to say, ‘oh my goodness, what would this do to our healthcare system let alone charities and education and all the rest?’ That was when the main battle was fought, when enough realization of the impacts of this bill. The third time it came forward, Friends of Medicare once again pointed out, ‘we haven't forgotten the serious impact that this bill would have,’ and it died. So Friends of Medicare was very instrumental in the Gimbel Foundation Act, and that was defeated, soundly defeated, although it was quietly withdrawn after the third time it went forward. The Regional Health Authority Act was really a time when the healthcare system around Alberta was carved up. It was very unclear what the roles of these boards would be, what authority

they would have, and also whether there'd be a very large push or an encouragement of those boards to privatize healthcare services and to allow funding for services in the hospitals. For instance, there was some discussion that the regional health authorities would be contracting out to private for-profit or that in a region a private company could come in and compete with a public hospital. There was also the allowing people to queue jump. If you want to pay for your MRI, you want to pay for your test, 'oh good we'll bring you in.' It's just a nice way of raising money, so you can jump the queue and everybody else can wait, because you're paying the public system a little bit extra. So the work of Friends of Medicare, working well with many other groups and bringing in other groups whenever it was needed, they made sure that this Regional Health Authority Act was something that really protected the healthcare system and protected the public. So they were very instrumental in making sure that that act, which was roughly drafted and then 50 some pages of revisions to that act, that those revisions were all in the best interest. Bill 31 was looking at contracting out to private for-profit, and the allowance of private for-profit to flourish in Alberta. What Bill 31 basically came down to was the fact that if you wanted to open up a private hospital or private clinic and get public money for the care that you're doing, you had to get a contract with the regional health authority of that area. So in other words, you wouldn't be able to have 100 different companies running into Alberta, building their own little clinics, and going after public funding. If they wanted to come in and pay the cost of building a hospital or clinic, they had to be entirely private. So again, the good work of the Friends of Medicare carefully working in collaboration with other groups to really get the government to rethink some of these bills and acts that would've had major short term and long term implications for access to healthcare, for quality of healthcare, and for even control of the spending for healthcare. Again there's a criticism that we're spending a lot on healthcare right now. But if we'd have allowed the for-profit companies, American companies and Canadian companies to come forward, we'd be spending a lot more for healthcare and we'd have people falling through the cracks, just as they do in the United States. People would get very little access to healthcare.

Q: How did the organization adapt after that?

DW: I think right now we're into a very interesting situation again, because we've got money coming into the healthcare system. In a recession, we actually have increased funding to the healthcare system by a billion dollars. A significant amount of that funding is going to the private clinics which were opened up in Calgary, not around the province but specifically in Calgary, which has always been the area where there's been the most tolerance to an American style of healthcare. Calgary, by the way, is the city in Canada where there are the most Americans living there. Again you've got some very wealthy people who may not realize that all it would take would be one major illness and they could go through their entire fortune and still not get all the healthcare that they need. A few years ago when they were closing hospitals in Calgary, blowing up one and closing down another one, there was a group that came in and bought up the old Grace Hospital. That's the HRG group that managed to get a contract with the Regional Health Authority to provide some surgical services. They sort of had managed to stay alive through thick and thin by getting access to public funding. In Alberta and across Canada there's not

much appetite for paying out of pocket for private healthcare. Because we have a high quality public healthcare system, so why would you want to basically throw ten or twenty thousand dollars of your own money away when there's a public healthcare system where you get very good healthcare? If your care is urgent, you get it today. If it's not urgent, then you'll wait a little bit but you will get healthcare. So this group that set up, this private surgical group that set up in Calgary, they were able to survive because they got a contract to provide publicly funded surgical services in Calgary, similar to the eye clinics in Calgary. In Calgary all of the eye surgery is privatized, it's all done in these private clinics. The interesting thing though is that these are day surgery clinics. If you go and you have your surgery during the day and then at midnight have to see a doctor because there's something wrong, you go to the public emergency department. This again is a very good example of creaming and dumping, that you want to try and avoid by keeping one healthcare system as opposed to where you have private and public working in the same area.

Q: Where is this all going?

DW: The interesting thing, I've looked into the history of Canada Health Act. Of course the Canada Health Act, as you know, was passed by all federal parties, supported and passed by all federal parties in 1984. But interestingly enough, it's very similar to the precursor act, which was in 1966, called the Medicare Act. The Medicare Act was almost identical to the Canada Health Act. When the Medicare Act was developed back in 1965 and passed in 1966 and caught on across every province then signed on within a few years to that so that we would actually have free hospital care, free medically necessary care, and also free physicians care, at that point almost all of the healthcare that you got was provided in a hospital or in a doctor's office. Today, with many more medications and day surgery procedures and outpatient treatments that can be done, there's much more sort of disagreement over what should be publicly funded. Back in 1965 and '66, everything in hospital was publicly funded, everything done in a doctor's office was publicly funded. Now you can see a chiropractor in a chiropractor's office. Should that be publicly funded? That's a very good example. If you take herbal medications from an herbalist or something like that, should that be publicly funded? So here's where we get into some of the cracks that have developed, because healthcare keeps improving, healthcare keeps adapting. We keep getting new technologies and new ways of treating illnesses. At this point in time, 90% of surgeries that you can have done could be done on a day surgery basis. So you come in in the morning, you have your surgery, and you're out by noon or 2 o'clock or 5 o'clock at the latest. The issue is that you had to prepare yourself for that surgery. You may have had to buy the supplies, the drugs, you may have had to get yourself by hook or by crook to that hospital so that you're there by 7 or 8 or noon or whenever it's scheduled. You probably already had to go through a number of diagnostic tests where you had to come in and out of work to come in and have your test, then go see the doctor and this and that. So the healthcare system today is quite different than it was back in '65 and '66 when the Medicare Act, which the precursor, very similar to the Canada Health Act, was passed. The whole reason we got into the Canada Health Act, why that was passed again, was to reaffirm that Canadians wanted a publicly funded, publicly delivered healthcare system and government-controlled healthcare system. So

we brought in the fifth criteria with the Canada Health Act, which was the accessibility clause that there'd be no user fees. What was happening prior to 1984 was that if you were admitted to hospital, you'd have to pay a fee. If you were in a doctor's office, the doctor billed you a little bit extra. If you spent 10 days in hospital, you'd get maybe a daily fee that you had to pay. Twenty days you'd pay twice as much than if you were in for 10 days. So there was extra billing that was going on. Yes, we had a publicly funded healthcare system, but they were making people pay privately out of pocket for whenever they used the publicly funded healthcare services. That's why the Canada Health Act in '84 was passed, was to outlaw these extra fees that people were paying when they were sick. There's some very good research at that time pointing out that poor people, when they had to pay a few dollars, even just a few dollars, when they went to emergency, when they were admitted to hospital, when they went to a doctor's office, that meant they went less. They didn't go when they needed to go to the emergency department or the doctor's office. They really were very severely impacted, even when the fees were quite small. So here's now where we're getting into the big challenges, which is with so much of healthcare being done on a day surgery basis. Ninety percent of surgeries, probably 99% of all diagnostic tests now are done on an outpatient basis. You come in in the morning, have your test, and you're gone by noon. So much of that has shifted the responsibility onto people, but also some major costs onto people. This is now why they say that 30% of all of the money that's spent in Canada on healthcare is private money, for all the drugs, the dressings, the preparation, and also some alternative treatments like chiropractic and what have you that's not covered by the public system. So that's a major challenge and it's a worry.

Q: What's giving the impetus to this?

DW: This is an interesting thing to think: why is the Alberta government repeatedly interested in private for-profit? I think much of it comes down to the fact of this kind of idea of why not. Why not let a few companies make money off healthcare? The idea that it's just another business, that it's not really a public service, but it's just an opportunity? What's wrong with people making money? Let's diversify the economy. Some probably also believe that if you have the private system, then a few people will move away from the public system and take pressure off the public system, so then we don't have to put so much money into the public system. So then you get into even a worse… again the issue of if people aren't using the public system, government doesn't want to put money into it and then it just gets worse and worse and worse. So I think there's a number of reasons. But Alberta is quite unique. Other provinces are not nearly as interested and have such a sustained interest in private for-profit healthcare. Once Alberta is identified as a place that is really open for business, they're a big target for the lobby groups, they're a big target for the American for-profit insurance companies, the other groups that realize, gee, I might be able to make my first billion dollars here. Alberta is a weak spot in Canada in terms of, like we're open for business, we're kind of tolerant. We're interested in private for-profit healthcare, so it keeps coming over and over and over again into Alberta. Until we change our government, probably Alberta will always be seen as the place where maybe Medicare can be broken. Maybe we can break this cross-Canada-wide system of

publicly funded universal healthcare. Alberta is seen as kind of the frontier where we can come in and maybe break this system.

Q: Do you recall the days of the Romanow inquiry?

DW: It's interesting when Romanow, when the royal commission was appointed. I guess it isn't surprising that a Liberal government would've asked Roy Romanow, a Saskatchewan premier from Saskatchewan to lead that. As we all know, that was a very well-funded exercise. Over a space of three years they commissioned papers, they met with many groups and many individuals across Canada. I remember presenting to him when he was in Edmonton here, about the same time as the Kirby Senate group was also going around the province in a parallel exercise. But in Alberta, many groups and individuals asked for support for a publicly funded healthcare system and in fact asked for federal and provincial governments to talk together with each other and work together with each other and collaborate with each other in support of a publicly funded healthcare system, and not to abandon or change in any way the Canada Health Act. So it's very interesting that Albertans, who were very well versed in what we could lose, really talked very strongly to Romanow when he was here. I listened to many of those people, because I was presenting to Romanow when he was here in Edmonton. I know he got the same message across the province wherever he went. He also got that same message across the country as well too, that there was no appetite to abandon a publicly funded universal healthcare system. I don't know how well he was received by the Alberta government, but he certainly was well received by Albertans and by groups across Alberta, who were very concerned. Private businesses started to realize that if they had to pay for health insurance for their workers, if they had to begin to fund the healthcare of their workers, private businesses began to realize, we could be like the United States where most people get their healthcare through their employer. Private businesses began to wake up and realize what they could lose if we began to pay privately for healthcare. So there were many, many groups that came forward when Romanow was here. I think Albertans had been woken up at that point and realized the opportunity to speak to Romanow and to really encourage sustaining the Canada Health Act and sustaining a public universal healthcare system.
… I think again Albertans had been woken up about what we could lose. I think Albertans have become very well informed on what the issues are. When you have the private for-profit, a parallel system or a tandem system, when you've got the two working together, in essence you have the American healthcare system with all of the problems that it brings in.

Q: But the Alberta government had its own strategy to counteract that very positive move – in Mazankowski.

DW: It's interesting. Also again I guess you've got a government that is still trying to manage and at times also a government that becomes very concerned about how people view it. Are they planning? Are they doing the right thing? So the Mazankowski Commission was formed almost overnight, almost around the same time the Romanow Commission was working. The Mazankowski group, interestingly enough, they had

nurses and doctors on that group. So it was quite a mix of people, very unlike the Alberta Health Services Board that is in existence today, which is almost all business people. The Mazankowski committee, the group, the board, or the members that sat in that committee, were quite a wide range of people. They were not all business people. But clearly they were a group that were in favour. They were careful to select people that were very much in favour of private insurance. We had people in fact that were, some of the board members on the Mazankowski commission were actually on the boards of private insurance companies, so no conflict of interest there. I guess it's not surprising then that the Mazankowski report that came out, the blue report that came out, was very much in favour of private insurance, so that people should buy private insurance to get extra care. They also in the Mazankowski report came out with the idea of having a certain amount of money that you could spend in your lifetime on healthcare. You would sort of accumulate points throughout your lifetime. If you lived in Alberta say for 80 years and you get so many points each year, well then you had these points to spend. They picked that up from looking at Singapore and some other countries that were kind of toying with it. But it's unfortunate that there were some good points, which is that we should have more health promotion, we should help people become well and stay well. There were a few good points in the Mazankowski report, but by and large this was a very predictable document that came out of a government that was very much in support of private for-profit as a separate option but also as something that should be real and live and supported in Alberta. So the Mazankowski Heart Institute now is quite an interesting flag to Albertans that here is someone who has remained quite prominent. Would he be prominent in another province that's not in support of for-profit healthcare? Probably not.

Q: What about the reduction of capacity and the need to strengthen our healthcare system?

DW: I think one of the biggest fallacies that we have right now is the idea that our public healthcare system has no more ability to expand, that in fact it couldn't handle a billion dollars; we have to take and put that money into the private system. Here's a very good illustration of why I think that's completely false. The cutbacks, when we went from 13,000 hospital beds to 6,500, when we closed half of those beds, the majority of those cuts were made to Edmonton and Calgary hospitals. The University Hospital is a very good illustration of that. It used to be 1,100 beds; today it's only about 650 beds open. There are many parts of that hospital that could open up tomorrow if the money was put into it. We've got operating rooms in the Royal Alex Hospital, the Misericordia Hospital, the Foothills Hospital – we have operating rooms that are not working seven days a week, they're not working eight hours a day even, some of them. We have emergency departments that could very easily be expanded if they just knocked down a couple of walls and opened them up. We have a healthcare system which is very flexible and adaptable. Again, it was cut back, severely cut back. We have the infrastructure there. We have big hospitals that we're only using a half to a third of or two thirds of. We have got still floors closed in hospitals around the province. We've got operating rooms and recovery rooms and everything that we're not using to full capacity. So thinking that we have to go to the private sector because that's the only place we can quickly expand, is completely false, particularly when you think of anesthetists being laid off at the Royal

Alex Hospital and now they're working in the private system. Nurses that couldn't get a job in a public hospital, well they have to pay the rent so now they're working in the private system. I have to say that one of the big concerns for me is this idea that you have to turn to the private system. Our public is there; we're not using it. It could easily expand.

Q: One of the crucial compromises in history was when Tommy Douglas in 1962 did not put the doctors on salary. The doctors have remained entrepreneurs.

DW: There's the kind of quirk of fate that it was the doctors that did not want to be brought into the public system that went on strike in Saskatchewan. I guess in some ways it's not surprising that they had to look at doctors separately where we have this fee-for-service system. But what I think people forget is the fact that the fee for service that each doctor gets, in other words the pay of doctors, that all comes out of the public purse. This idea that doctors are private entrepreneurs, they're paid by the public purse. They are public servants just like I am. I am paid by a university. When I work in a hospital I'm paid by the hospital – it's all public money. Doctors are paid from the public purse as well too. The real issue in my mind about fee for service is the fact that here's where doctors are rewarded for the more people that they get through their door. Not the comprehensive care that is needed, but it's the six minute patient. I need to get you in and out in six minutes so I can get the next paying customer in. This is where the public has been shortchanged, because you get some people that need a half hour of the doctor's time, you get other people that maybe need an hour of the doctor's time. So their health concerns I don't think have been adequately met by a fee-for-service system of how doctors are paid. But again, doctors are only private entrepreneurs in that a number of them have an office that they pay for. That's how they're entrepreneurs. They're still paid for by the public purse. Our tax dollars pay the doctor's wage.

Q: Doesn't the doctor get paid more when he sees me for half an hour as opposed to six minutes?

DW: No, it's per service. So if you do a major examination that you do in one minute, you get the same pay if that took 20 minutes or an hour. You get the same amount of money – it's per service.

Q: Is there anything else?

DW: Let me just give some thought to it. I'd like to maybe just wrap up about Friends of Medicare. I think one of the great triumphs that Friends of Medicare really needs to be recognized for is the fact that they can take young and old people, rich and poor people, people who are healthcare providers or healthcare professionals, and people who are users of the healthcare system, and they get them all together and working together. There's a common goal. It meets people's needs and it's an amazing organization. If there's a criticism that they're only reactive, that wouldn't it be nice if they could be well-funded and be proactive like the Parkland Institute, to me again that's really forgetting the

fact of what a terrific group this has been. It's good for the people that come together and boy is it ever good for the public. It's an amazing organization.

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