Both sides made some concessions in the Saskatoon Agreement. The Government agreed that the doctors could seek care privately and pay a doctor directly if they wished; that the non-profit prepaid medical care schemes could continue to work in partnership with medicare; and that the commission would report to the Legislature.

The doctors for their part recognized they could not compel the Government to change legislation by strike action; they accepted the principle that doctors could work on salary from the commision if they wished; and, most important of all, they recognized the Government's medicare plan.

How does it stand now, 10 years later?

Doctors retain the feedom to bill for medical services in several ways: through medicare, through the non-profit plans, to the patient who can be reimbursed by medicare or by private agreement with a patient. This is a freedom no longer available to Ontario doctors, who last November had to choose either to bill medicare or bill their patients. Saskatchewan doctors can use all four methods in their practice if they wish; Ontario doctors must choose one method or the other for all patients.

In practice, the majority of doctors bill medicrae. The two approved health agencies, Medical Services Inc. and Group Medical Services, still exist, but have become more post offices, which reroute claims to medicare. As every year passes, fewer patients and doctors use them and both schemes have switched most of their activity into covering extra benefits, such as ambulance service, private nurses, drugs and others, much as Blue Cross has done in Ontario.

Not all, however, is sweetness and light.

Some of the fears the profession entertained in 1962 remain and have been reinforced by the re-election of the New Democratic Party last year and also, curiously, by trends increasing throughout Canada for new forms of health services.

One, which ties in closely with the political creed of the Saskatchewan Government and its labour supporters, is for walk-in community health centres providing integrated health and social services, which is proposed as a means of reducing admission to hospital, a move aimed at cutting costs.

Walter Smishek, 47, the present Health Minister, opposed running medicare through a commission, rather than integrating it directly into the Health Department; opposed fee-for-servic payment of doctors, preferring salary; opposed deterrent fees; and disliked premiums for medical insurance, preferring ficome tax.

Deterrent fees have already been removed for all as have premiums for those over 65. Premiums produce only a small proportion of medicare revenue (about $5.7-million against a total cost of more than $37.5-million). Premiums are the same now as when they were first set in 1962: $12 for a single person and $24 for a family a year (hospital insurance costs an additional $24 and $48 respectively).

While criticizing fee-for-service as a piecework system that "thrives on quantity and undermines quality of care," creates cumbersome administration and promotes wasteful competition, Mr. Smishek says he recognize circumstances may compel its retention in some form.

But it is the Government's plants for community health centres integrating health and social services that cause the most uneasiness among many doctors. They are feared as the firse step toward a system that could sound the death knell of independent, fee-for-service medical practice and traditional control of health services by doctors.

Integration of health and social services cannot avoid eroding the process where he becomes one professional among equals. Consumer participation could become consumer control, where all professionals are directed by lay boards: there are groups in Saskatchewan pressing for exactly that. The more pessimistic fear that from there it is a short step to direct operation by Government fiat.

In an interview, Mr. Smishek said community health centres "will not be forced down people's throats." He said regional health planning councils should include consumers, as well as providers; should plan health care within the whole context of social services and education; should be based on an "economically viable" region, although it should not be too large; and should produce a flexible system to cope with population changes.

But, he said, the Government will be cautious so that people