November 11, 1989, military offensive. It was, she says, El Salvador's "Tet."

The war had become a stalemate as early as 1984. Until then, the FMLN had been winning, but the United States, determined not to permit a communist victory, increased its involvement. It promoted the drafting of a new constitution in 1983, poured $1.8 million into El Salvador's 1984 presidential elections, won by Christian Democrat José Napoleón Duarte, and provided his government with up to $1.2 million a day to fight the war.

The Reagan administration's commitment ruled out an FMLN victory, but the U.S. Congress's refusal "to condone either an open alliance with the violent ultraright or intervention by U.S. troops," says Karl, prevented the FMLN's total defeat. The war dragged on, costing tens of thousands of lives and devastating the economy. By September 1987, opinion polls indicated that more than 80 percent of the Salvadoran people wanted a negotiated end to the war.

Like the 1968 Tet offensive in Vietnam, the FMLN's November 1989 offensive—in which the guerrillas carried out a wave of attacks in the capital city of San Salvador—was a military failure that nevertheless fatefully altered perceptions. [The Tet offensive in Vietnam, in fact, was misperceived as a U.S. "disaster."] The failure of the Salvadoran rebels' offensive demonstrated what most on the Left already knew: that they did not have enough support for a widespread popular uprising. The opening of the Berlin Wall that same month and the Soviet Union's decision earlier in the year to cut off arms shipments to Nicaragua's Sandinista government also helped deflate rebel hopes. On the Right, Karl writes, "the rebel occupation of homes in the wealthy Escalón district [of the city] galvanized recalcitrant Salvadoran businessmen to support negotiations," despite the military's opposition to talks.

The Salvadoran army's murder of six Jesuit priests later in November was the final straw. "What died with the Jesuit priests was a [U.S.] foreign policy consensus based on the twin premises that the [Salvadoran] army had successfully contained the FMLN and that democracy was being constructed." Opposition by Democrats on Capitol Hill made it clear that U.S. aid to El Salvador's armed forces would soon be shut off. On February 1, 1990, U.S. Secretary of State James A. Baker came out for "a negotiated settlement which guarantees safe political space for all Salvadorans," thus reversing U.S. policy. The stage was set.

Two years later, the peace treaty was signed in Mexico City. Conservative President Cristiani "strode across the podium to shake hands with all five FMLN commanders as participants on both sides cried openly." Yet "fear and uncertainty" are bound to persist, Karl says, at least until the March 1994 presidential elections.

Saudi Democracy?

"Saudi Arabia: Culture, Legitimacy and Political Reform" by Joseph McMillan, in *Global Affairs* (Spring 1992), International Security Council, 1155 15th St. N.W., Ste. 502, Washington, D.C. 20005.

Oil wealth has brought rapid increases in urbanization, education, and overall living standards in the Kingdom of Saudi Arabia in recent decades. Does all of this material progress mean, as some Americans wanted to believe after the 1990–91 Persian Gulf War, that Saudi Arabia is moving inevitably toward democracy? Not at all, says Joseph McMillan, former U.S. Defense Department country director for Saudi Arabia.

The cornerstone of the Saudi political system is the Islamic faith, he points out. It—not the will of the people—is for Saudis the ultimate authority in the land, which the monarch must uphold. The Saudi population is wholly Muslim and overwhelmingly Sunni; no more than seven percent of the Saudis—about 550,000—are Shiites. Democracy has made inroads in other Muslim nations—notably, Pakistan, Turkey, Jordan, and Egypt—but that does not mean that Saudi Arabia is its next likely stop. Saudis set themselves apart from other Arabs and Muslims. Regarding themselves as the most Islamic of Muslims, Saudis take pride in their strict adherence to a distinctively Saudi fundamentalist form of Islam called Wahhabism, named after Muhammad ibn Abdul Wahhab, an 18th-century religious reformer. Government's main purposes, in the Wahhabi view, are to guarantee the purity of the faith, to protect and defend the faithful, and to preserve order in the Muslim community (*ummah*). If the *ulama* (religious scholars) pronounce the ruler un-Islamic, then the subjects have a positive duty to disobey him.

This means that the monarchy has to share

Canadian Health Care: Cure or Disease?

A Survey of Recent Articles

Americans are usually not much concerned with what happens in Canada, but in recent years one feature of Canadian life has attracted a great deal of notice: its health-care system. Canada provides universal access to high-quality medical care and seems to be controlling costs better than the United States is. In consequence, health care Canadian-style has been extravagantly praised, fiercely attacked, and sometimes even closely examined.

Americans are unhappy with the soaring cost of U.S. health care, surveys indicate, and their consciences also may be somewhat nagged by the fact that an estimated 37 million of their fellow citizens under 65 have no health insurance at all. Searching for an answer, they wonder if Canada has found it. The American Medical Association insists that it has not—and has spent millions of dollars on advertisements attacking the Canadian system. The Health Insurance Association of America has joined in. And President Bush last February called Canada's approach "a cure worse than the disease." Yet public opinion surveys in Canada consistently indicate overwhelming support for that "cure." Canada may not have created utopia, but Theodore R. Marmor, a professor of public policy and management at Yale, says in *Current History* (Dec. 1991) that it is doing better than the United States at providing broad access to health care and managing the costs. In 1990, according to the *New York Times* (Feb. 17, 1992), per capita health-care spending (in U.S. dollars) was $1,991 in Canada and $2,566 in the United States. And the Canadian system, Marmor writes, "is as adaptable to American circumstances as one could imagine a foreign model to be."

Until 1971, when Canadian Medicare was first fully in place, the patterns and styles of medical care in the two countries were almost identical. Today the 10 Canadian provinces provide coverage for all necessary hospital and medical care for all their citizens, with no limits on necessary services and no extra charges to patients for them. There are federal guidelines, and Ottawa pays 40 percent of the system's costs. The provincial governments negotiate with the hospitals and doctors every year to determine hospital budgets and set physicians' fees. Much as in the United States, doctors engage in private practice and are paid on a fee-for-service basis. Patients choose their own doctors, but doctors bill the province.

Because the provincial ministry of health is the only source of payment for all covered health services within each province, and because the rules for coverage and reimbursement are uniform, the costs of health-care administration are greatly reduced. In the United States, administrative costs accounted for an estimated one-third of physician and hospital expenses in 1991, according to analysts John F. Sheils, Gary J. Young, and Robert J. Rubin of the Washington-based consulting firm Lewin/ICF. Much of the cost of administering U.S. health care, they say in *Health Affairs* (Spring 1992), "can be traced to the fact that insurance is provided through roughly 1,500 separate private and public sources of coverage, each with [its] own rules, forms, and provider reimbursement policies." Usually, the provider must bill two parties: the insurer and the patient. The Canadian system eliminates both the complexity of diverse insurer rules and the multiple billing. (Canadian hospitals send no bills at all but work from their annual operating budgets.)

Estimates of potential savings if the Canadian system were adapted here vary widely. Estimates by Steffie Woolhandler and David U. Himmelstein in the *New England Journal of*

power. The Saudi *ulama* are often depicted as having lost much clout in recent years, but radical Wahhabi leaders still have been able to derail major government moves toward modernization. During Operations Desert Shield and Desert Storm, King Fahd and the royal family took pains to placate the religious leaders.

Being alone able to challenge royal power, the *ulama* "would almost certainly oppose any serious democratization of Saudi life," McMillan notes. Although, shortly after Operation Desert Storm, *ulama* leader Sheikh Abdul Aziz bin Baz and other prominent religious figures did call for King Fahd to establish a consultative council of senior officials, this was hardly a manifesto for democratic reform. Nothing was

Medicine (May 2, 1991) suggest that the Canadian approach might have cut the U.S. health-care bill in 1991 by more than $100 billion. Sheils and his colleagues put the savings at $46.8 billion. But they add that such savings would have been more than offset by a $78.2 billion spending increase resulting from greater use of the "free" comprehensive care. (Only $11.1 billion of that increase would represent increased use by previously uninsured persons.)

Although proponents of the Canadian approach may be overselling its advantages, Canada does appear to have done a good job controlling health-care costs. In the early 1960s, before it moved to universal health insurance, Canada spent about six percent of its gross national product (GNP) on health care—slightly more than the United States' 5.5 percent. In 1989, U.S. health-care spending, as a share of GNP, had risen to 12 percent, while Canada's was only nine percent.

This Canadian achievement is just an illusion, contends Heritage Foundation analyst Edmund F. Haislmaier in *Policy Review* (Fall 1991). Echoing a 1990 Health Insurance Association of America argument, he says it is "misleading" to use percentage of GNP as a basis for comparison. Canada's ratio of health-care spending to GNP is lower, he says, only because its GNP grew more rapidly. Using another gauge, he notes that between 1967 and '87, per capita health-care spending, adjusted for inflation, increased by 4.38 percent annually in the United States—and 4.58 percent in Canada.

That argument cuts no ice with Morris L. Barer, director of the Centre for Health Services and Policy Research at the University of British Columbia, W. Pete Welch of the Urban Institute in Washington, D.C., and Laurie Antioch of the Australian Treasury. Writing in *Health Affairs* (Fall 1991), they say that share of GNP is the only reasonable gauge of a nation's relative success in containing health-care costs. It cannot be measured, they say, by comparing trends in real costs per capita. Canada's economy grew more rapidly than the U.S. economy in 1967–87. In the long run, economic growth means higher wages in the health-care sector, as in others. But that, they say, surely is not evidence of a failure to control costs.

Moreover, they point out, the 1967–87 period, which was chosen by Haislmaier for examining growth in real costs per capita, includes four years in which the Canadian system was still being developed and put in place. During 1971–87, U.S. real per capita costs rose slightly *faster* than those in Canada, despite the fact that Canada had more rapid real economic growth. In 1988 and '89, the rate of real growth in per capita health-care costs *declined* in Canada while *increasing* in the United States.

What about the short supply of some high-tech medical equipment, the long waits for urgently needed surgery, and other horrors of the Canadian system often dramatized in the news media? It is true that magnetic resonance imaging and certain other types of advanced technology are not as readily available in Canada as they are here. However, Marmor points out, "If... quality [of care] is defined by results rather than by the use of high technology, then there is no evidence of a Canadian disadvantage." In fact, in terms of life expectancy and infant-mortality rate, Canada has the advantage.

As for those lengthy waits by patients, Ottawa resident Jordan Bishop tells in *Commonweal* (Mar. 27, 1992) what happened to a colleague who suddenly needed coronary artery bypass surgery. "He lived in Nova Scotia and underwent the bypass operation in Toronto—1,600 miles away—four days later. It was successful. This picture, most Canadians would say, is far more typical than delays for urgent treatment. What is much more important to most Canadians is that ordinary, essential, and routine things such as prenatal care, childbirth, and postnatal care are effectively and efficiently provided to everyone who needs them." Perfect it may not be, but Canada's health-care system is hardly a cure worse than the disease.

said about elections.

Religious resistance to serious democratization extends well beyond the *ulama*, McMillan says. "Other than in the veneer-thin layer of the mercantile technocratic elite, there is no indication of widespread dissatisfaction with the Kingdom's Wahhabi culture."

Yet if democracy does not seem to be in the cards for Saudi Arabia soon, all is not dark. "[W]hile far from a democracy, Saudi Arabia is not a tyrannical police state of the kind so prevalent in the Middle East." Most Americans would find life there oppressive (as do some Saudis), McMillan says, but at least the Saudi government "is fundamentally decent and [shows] a civilized regard for human dignity."