Social Rights and Non-State Welfare in the Middle East

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Introduction

Across the developing world, non-state providers (NSPs) play a large role in welfare regimes. In many countries, NSPs have always been the main providers of welfare, even after countries across Africa, Asia, and the Middle East gained independence and their new rulers embarked upon ambitious state-building projects. In countries where post-colonial governments established more extensive public welfare programs, fiscal crises and development policy prescriptions have generally reduced the state's role in social service provision and social protection since the 1980s. Thus, now more than ever, non-state actors are key components of welfare regimes in the global South.

In the Middle East, the regional focus of this essay, the rise and reinforcement of NSPs has received some scholarly and policy attention, particularly regarding the role of Islamists as providers of social services (Alterman and von Hippel 2007; Bayat 2002; Cammett 2014; Clark 2004; Flanigan 2008; Hamzeh 2001; Harik 1994; Ismail 2001; Malka 2007; Őniş 2006; Walsh 2006; Wickham 2002; Wiktorowicz 2004). In most countries in the region, political elites initially adopted statist development with substantial investments in public education, health care, and infrastructure. As a result, governments fueled significant advances in human development in the first decades after independence. With the onset of fiscal crises in the 1980s, many of these policies were dismantled or were left to erode, while old and new non-state actors became increasingly important providers of welfare and guarantors of social protection.

In this essay, I explore the implications of this regional trend towards the experience of social rights in Middle Eastern countries. What happens to the concept and substance of social rights when they are delivered and/or guaranteed by entities other than the state? The answer to this question should be nuanced. On the one hand, it is clear that the poor are the first to lose when public services erode and entitlements are cut because they cannot afford services supplied by most NSPs. Furthermore, the main beneficiaries of post-independence public welfare programs were members of the upwardly mobile, educated middle class, who therefore experienced the most immediate and tangible negative shock from the erosion of public services and programs. On the other hand, as the previous statements indicate, the main beneficiaries of social services and programs provided or administered by the state were formal sector workers. As a result, the rise of NSPs may have little to no impact – or may even help – those who were marginalized in post-independence welfare regimes. Ultimately, the effects of non-state welfare provision on social rights depend on the nature of the NSP in question, its relationship to the state, and on the capacity of the state to regulate the provision of welfare at the local level.

In the next section, I elaborate the main concepts and claims in the essay. The third section provides some basic background on welfare regimes in the Middle East focusing on the health sectors in two countries, Jordan and Lebanon. Despite their common origins as colonial constructions carved out of the former Ottoman Empire, these two countries represent two very different types of welfare regimes in the region and therefore offer distinct institutional and economic contexts within which NSPs operate in the contemporary period. The fourth section speculates about the implications of non-state welfare provision in Jordan and Lebanon for two dimensions of social rights, including access to welfare and the accountability of providers to the public. The final section summarizes the main claims and suggests areas for further research.

Non-State Welfare and Social Rights

Social rights, or the right to a modicum standard of living within a given social context, are often understood to include access to basic services such as health care and education. The public sector may or may not actually provide these services, but at a minimum the concept of social rights implies that states guarantee social rights by ensuring relatively equitable access for citizens, and sometimes also for non-citizen residents, within the national territory. The substance of social rights and the institutional arrangements of relevant programs and policies obviously vary from country to country. When state capacity to provide and regulate social welfare is weak and NSPs predominate, however, the concept and reality of social rights are tenuous at best. Before discussing the implications of non-state welfare for social rights, it is first necessary to clarify the main concepts addressed in this essay and the nature and multiple manifestations of non-state welfare provision.

Access to Social Welfare

At the most basic level, the experience of social rights entails access to a minimal package of social services such as medical care, education, and social assistance. The concept of access includes multiple dimensions such as *financial* access (i.e., Can most or all people afford to pay for services?), *geographic* access (i.e., Are providers and facilities sufficiently close to those who need services? Are some areas underserved?), the *quality* of services (i.e., Are services of such poor quality that people are effectively denied access to care?), and *cultural* access (i.e., Are services provided in a way that are in line with the cultural norms of the community? For example, are female gynecologists available for women in conservative societies?).

Equity and sustainability are central to the question of access to social services and benefits. As noted above, both the quantity and quality of social services received by citizens determine the equity of access to social welfare (Castro-Leal, Dayton et al. 2000; Pritchett 2004; Sarker and Davey 2009; McGuire 2010; Hill, Baxen et al. 2012). If services are available and affordable, but are perceived to be so poorly delivered that recipients decline to use those services or do not receive adequate and appropriate care, then the equitable distribution of social welfare is effectively reduced. For example, across the Middle East and in many other developing and post-communist countries, citizens perceive public facilities to offer lower quality services than private, for-profit providers. In effect, then, those who cannot afford private services may feel that they have inferior access to health care, schooling, and other basic services.

Access to social welfare is also contingent on the sustainability of access. Sustainability refers to the durability over time of a provider in a given area of service delivery. States are relatively enduring sets of institutions, even if their "caretakers" (i.e., governments) may be ephemeral. Some types of non-state actors, however, are less stable perhaps because their organizational structure is weak or access to and the renewability of financial support is uncertain.

The concept of sustainability also incorporates the extent to which non-state provision is socially embedded, where communities and citizens have some ownership in the delivery process and are invested in the future. In this respect, locally-rooted actors may have an advantage over international organizations or domestic actors based in faraway regions because they tend to be more attuned to community needs and therefore supply services that people seek in an appropriate manner.

Accountability

Accountability refers to the responsiveness of providers to citizens or community members. The existence of channels that enable citizens or beneficiaries to provide feedback on services, have some say in what they receive, and put demands on their providers is a core component of accountability. Accountability with respect to social welfare entails the ability of citizens to hold providers liable for the quantity and quality of services received and, more fundamentally, for the process and experience of seeking and obtaining services.

The rise of NSPs has potentially important and direct implications for accountability. Non-state provision may affect whether and how citizens demand accountability around their access to social welfare. At the most basic level, NSPs do not have the same obligations that, at least theoretically, bind states to citizens. To the extent that NSPs tend not to have mandates to serve broadly or indiscriminately, they are less accountable to beneficiaries and the communities where they operate. Depending on the terms of their establishment and eligibility criteria, NSPs often have no obligation to serve all citizens universally, even those with demonstrated need or who lack alternative welfare channels. As a result, it may be harder for people, and especially the poor and vulnerable, to identify providers or to demand restitution for insufficient or ill-rendered services.

The social ecology of non-state welfare may also diminish the accountability of providers to citizens. NSPs are often small and operate in a fragmented terrain of social service providers, particularly in welfare regimes with greater numbers of non-state actors. Smaller institutions – even those whose staff have the best of intentions – may lack the administrative capacity and scale to institute mechanisms for ensuring accountability to community members. This problem is compounded in the context of fragmented systems of social service delivery, which make it harder for citizens to locate appropriate providers and, if necessary, to assign blame to and seek compensation from specific entities. Fragmentation among NSPs can be addressed through the formation of larger umbrella associations, but these associations usually favor more established NSPs serving more elite populations (Rose 2006). Non-state provision, then, potentially diminishes the responsiveness of providers to beneficiaries and, in turn, may make access to services less equitable.

The logics of these arguments appear to presume that states are necessarily superior in providing social protection; however, the reality in many developing countries is often more complicated. Many states lack the administrative and financial capacity to meet the basic needs of their citizens, or corrupt and negligent rulers disregard populations while favoring segments of elite supporters. In general, however, accountability is easier to attribute in sectors with fewer providers than in a fragmented sector with many small providers. In addition, by the 21st century, norms (although perhaps not realities) of state guarantees of minimum levels of social protection have spread globally, particularly among middle-income countries (Seekings 2008). Furthermore, to the extent that states adopt even a rhetorical commitment to rights-based citizenship, then populations are more likely to hold public providers accountable for their welfare experiences. As a result, welfare regimes with multiple NSPs can be less conducive to accountability than systems with greater state involvement, as credit and blame are easier to attribute to a smaller number of actors who have at least nominal commitments to the public.

Non-state provision may also have more indirect effects on the everyday practices of political participation and relationships between citizens and their states. Encounters with NSPs may mobilize and empower citizens participate more vigorously in politics (or, conversely,

interactions with NSPs may have the opposite effect), and may influence whether and how they demand accountability from their governments.

Types of non-state providers

The ramifications of non-state welfare provision for access and accountability depends in large part on the nature of the provider itself. What are NSPs and how do they affect the experience of social rights?

A diverse array of domestic and international NSPs interacts with citizens and states to provide social welfare, particularly but not exclusively in developing countries. These include for-profit institutions, secular organizations, ethnic and sectarian groups, faith-based organizations, informal brokers, community-based organizations, and family networks, among other actors. Each of these NSP types has distinct qualities, which lead to varied relationships with citizens and states. Table 1 describes four key dimensions of variation among NSPs, which should be seen as continua rather than dichotomous distinctions.

Table 1:Characteristics of NSPs

Dimension	Range of Indicator
Level of personalization	Formal/rule-based ↔ informal/personalized
Locus of operation	Local ↔ international
Profit orientation	Not-for-profit ↔ for-profit
Eligibility criteria	Inclusive ↔ exclusive

Each of these factors, including the degree of organizational formalization, locus of operation, profit-orientation, and eligibility criteria of NSPs, potentially affects access to social welfare and the accountability of providers to key stakeholders.

First, the degree of organizational formalization within the NSP influences the relationship between NSPs and citizens, with direct implications for access and accountability. Some NSPs operate on an informal, highly personalized basis whereas others function according to formal, rule-based interactions. When informal organizations have less transparent and institutionalized decision-making processes, it is more difficult for community members to perceive why and how resources are distributed and to present claims or requests. In general, informality complicates efforts to understand allocation processes and may deter those outside of connected social networks from seeking support in the first place. As a result, NSPs that incorporate personal factors in their interactions with citizens may serve more circumscribed communities.

Second, the proximity of NSPs to the communities they serve potentially shapes the ability of citizens to access social services or demand and receive responsiveness from providers. When NSPs are less locally embedded, perhaps because they are outposts of large international non-governmental organizations (NGOs), it can be more difficult to trace the procedures for obtaining benefits or mechanisms for claim-making. To be sure, the difference between domestic and international NSPs is often blurred. For example, some NGOs operate internationally or receive extensive funds from foreign states and donors but are firmly rooted in a particular domestic setting and are considered "local" actors. However, if members of the community

actually know the key decision makers who run the office on the ground, they may be more inclined to seek services from them, even if their financing comes from abroad.

Third, the profit orientation of providers has potential political effects by establishing new boundaries of inclusion and exclusion in welfare systems. For-profit providers are more likely to be inaccessible to the poor than institutions which do not need to maximize financial returns. For example, since the 1970s, private schools and health care providers have emerged and/or grown exponentially across many Middle Eastern countries. These for-profit providers cater to the emerging middle classes who are not satisfied with crumbling public welfare infrastructure and are largely out of reach for those who lack the means to pay for their services.

Finally, the eligibility criteria for receiving services have direct bearing on access to social welfare and more indirectly on the accountability of providers to the communities where they operate. NSPs exhibit distinct norms and practices of social inclusion and exclusion in the delivery of services, with some more exclusionary and others more egalitarian. NSPs that explicitly or implicitly favor some potential beneficiaries over others – whether based on class, gender, ethnicity, religion, partisanship or other forms of social stratification – provide more limited access to their services than universal, citizen-based programs theoretically offer. Furthermore, some NSPs have visible and transparent eligibility criteria, enabling citizens to readily assess their likelihood of obtaining services; others have more opaque requirements, making it difficult to determine the prospect for accessing social welfare and increasing the discretionary power of providers in the allocation of benefits. Not only does the transparency of criteria for access affect the ability of citizens to gain access to services, but it also shapes the likelihood that citizens demand accountability from their providers. If beneficiaries are uncertain about their ability to access services, they are less likely to place demands on the providers, particularly when they are poor or marginalized.

In any given country or even sub-national community, multiple types of NSPs inevitably operate. Nonetheless, in some contexts, particular types of NSPs may dominate or play a critical or growing role in social welfare provision, particularly for poor communities where individuals and families are often constrained in their choice of providers of social welfare.

How do NSPs affect access and accountability?

In the preceding sections, I suggested that specific characteristics of NSPs shape access to social benefits and the accountability of providers to members of the communities where they operate. The capacity of the state to regulate and sometimes to provide social welfare also affects the ways in which non-state welfare affects access to services and accountability. When states have the political will and administrative capacity to gather information on the range of providers operating in their national territory, hold them to standards, and ensure a relatively equitable distribution of services, then access and accountability are enhanced. Of course, these are big conditions that are not often met, even in the most administratively developed polities.

Together, NSP characteristics and levels of state capacity combine to shape distinct patterns of NSP-state relations. In turn, these relationships jointly affect my outcomes of interest – access and accountability. Table 2 depicts distinct patterns of NSP-state relations based on the capacities of each actor to finance, deliver, and/or regulate social welfare.

Table 2: Patterns of NSP-State Relations

		State Capacity to Regulate and/or Deliver Social Welfare	
		Low	**High**
NSP Capacity to Deliver and/or Finance Social Welfare	**Low**	**Appropriation** (i.e., NSPs control access to state resources through brokerage, patronage, credit-claiming)	**State Domination** (i.e., state control over financing and delivery of services)
	High	**Substitution** (i.e., NSPs take over when state does not perform or provide)	**Co-production** (i.e., joint financing and/or delivery of services by state and NSPs) and/or **delegation** (i.e., authority granted to NSPs to finance and/or deliver services)

State capacity refers here specifically to the state's ability to regulate and sometimes even to deliver social welfare, a more narrow definition than most political science definitions of this concept which tend to privilege the provision of security and/or the ability to generate tax revenues (Weber 1946; Levi 1989; Lieberman 2003). Importantly, this entails the ability of state agencies to finance and deliver social welfare services directly, but also, critically, its power to monitor and regulate the non-state actors involved in social welfare provision within its borders. NSP capacity is captured by the scale and formalization of the network, group, or organization that provides or finances social services; the quantity and quality of human capital in the NSP; and, the level of financial capital available for social welfare provision (Fowler 1997; Tandon and Bandyopadhyay 2003; Banerjee 2006; James and Haily 2007; Huyse, Molenaers, et al. 2012).

Various combinations of low versus high state capacity and low versus high NSP capacity yield four different patterns of NSP-state relations. When state capacity and NSP capacity are both low, a relationship of *appropriation* emerges. Appropriation describes a situation in which NSPs control access to state resources by serving as brokers for state-provided benefits or by distributing public services as a form of patronage. Appropriation may even entail credit-claiming by NSPs for services that they do not actually provide, or finance, themselves. In Middle Eastern countries where states have established yet declining public welfare regimes, the role of Islamists and other NSPs in national welfare regimes is aptly described in terms of appropriation .

When state capacity is low, but NSP capacity is high, the ensuing pattern is *substitution*. Here, NSPs are able and willing to take over social welfare functions from the state when it is not performing or to provide services that the state never provided in the first place. In contexts where public welfare functions were never well developed, the role of actors such as religious charities and NGOs can be depicted in terms of substitution. For example, in some sectors and regions of Lebanon, Hezbollah and other non-state actors effectively substitute for the state, which fails to provide water or electricity in parts of the country, at least not on a continuous basis.

Not many developing countries exhibit high state capacity for the delivery and regulation of social welfare, but there are some exceptions. When the capacities of the state and NSPs to regulate or supply social services are both high, the resulting pattern can range from *co-production* to official *delegation*. For example, in some Middle Eastern countries, states contract out the delivery of certain services to local and international NGOs, even when public agencies are capable of delivering them on their own, although examples of this type of relationship are not common.

When high state capacity combines with low NSP capacity, the dynamic is one of *state domination*. In most developing countries, even under authoritarian rule, state domination of welfare regimes is rare. In the Middle East, relevant examples include the oil-rich Gulf monarchies, which enjoy sufficient resources to deliver generous packages of benefits to citizens and, as a result, non-state actors play a less developed role in their welfare regimes. Even in the wealthy Gulf countries, however, for-profit providers in the health and education sectors are becoming increasingly important. Although it is far less wealthy, the Jordanian government too has the capacity to exert relatively high levels of control over service delivery, particularly in the health sector, as I discuss more below.

How do NSP types and state capacity jointly affect access to welfare and the accountability of non-state actors who supply social services?

First, the type of non-state actor delivering social welfare has direct effects on access to social welfare, as described above. In general, more formalized, locally-based, and inclusive NSPs that do not operate according to profit maximization principles are more likely to afford greater access to social welfare for citizens. Almost by definition, more inclusive eligibility criteria reach and attract a broader pool of beneficiaries. Different types of NSPs are more or less likely to serve broadly as expressed in their formal mandates and informal practices. Some NSPs explicitly aim to serve the largest possible array of beneficiaries, usually according to need-based criteria, while others effectively serve a more narrow pool of beneficiaries. Even after accounting for resource endowments, which constrain all but the wealthiest providers, some NSPs prioritize specific communities or categories of citizens, whether by race, ethnicity, religion, gender, or other forms of social stratification.

More formalized and less personalistic organizational management practices also limit discretion in the allocation of benefits. This can encourage more people to seek assistance in the first place, thereby broadening access to welfare. In general, more formalized organizations have more transparent and institutionalized administrative practices, which clarify eligibility criteria. Providers that are rooted in their communities are more likely to understand the needs of the community and may therefore initiate programs that address local concerns more effectively and appropriately and engage in more regularized exchange between providers and beneficiaries. Local embeddedness also enables citizens to obtain more direct knowledge of programs and to establish or benefit from ties with staff members, which may enhance their willingness to seek and receive services. Finally, for-profit providers are more likely to prioritize or incorporate financial concerns in the allocation of benefits, putting the poor and marginalized at a distinct disadvantage.

The relationship between NSPs and the state may also affect access to services. To the extent that the NSP-state relationship is collaborative – or at least not competitive – it may improve access to services and citizen experiences of seeking services. When NSPs and public agencies

work together, the total pie of programs and benefits may be enlarged. Furthermore, more cooperative and institutionalized ties between direct providers and the state facilitates the process of supplying services and improves the state's capacity to regulate other suppliers, which in turn can enhance citizen access to social welfare as well as the ability of beneficiaries to offer feedback on services rendered and to put demands on providers.

NSP type also has implications for the second outcome of interest, accountability. In the ideal world, all providers – NSPs included –accept responsibility for both citizen experiences in accessing services and for the quality and outcomes of their programs and benefits. In reality, some types of NSPs are more likely to be responsive to and accept liability for their interactions with citizens. A priori, more formalized and locally-rooted NSPs with clear eligibility criteria are more likely to be accountable to citizens. Greater transparency almost by definition increases the potential accountability of providers to the communities they serve. Profit orientation, too, may promote accountability to individual citizens, but can also reduce responsiveness to the broader public. On the one hand, the profit motive can make for-profit institutions more responsive to their "clients," who can take their business elsewhere if they are not satisfied with their service experiences. On the other hand, the power embodied in consumer choice is the privilege of those with means, excluding the majority of less fortunate citizens from accessing services or at least placing them at the mercy of the provider.

The relationship between NSPs and the state may also influence the likelihood that citizens can and will hold NSPs accountable, although the particular configurations of NSP-state relations under which accountability are improved are not clear-cut. When the state has and exercises existing abilities to monitor and sanction the actions of non-state providers, whether in a relationship of co-production or state domination, NSPs are likely to be more responsive to citizens. When state capacity to regulate NSP activities is low, NSP accountability to citizens can be reduced. Indeed, higher state regulatory capacity may be a necessary albeit insufficient condition to create accountable relationships between NSPs and citizens.

In the remainder of this essay, I present some broad, illustrative observations about the role of NSPs and their effects on access to welfare and accountability in two Middle Eastern countries with distinct welfare regimes, Jordan and Lebanon. The next section provides background information on the development of welfare regimes in the region as a whole and in these two countries in particular.

The Rise and Decline of Public Welfare in the Middle East

The literature on the political economy of development in the Middle East presents distinct understandings of socioeconomic models and practices in the region. One approach posits that the entire region is characterized by "authoritarian bargains" based on an "interventionist-redistributive" social contract. In this depiction, the state plays an active role in the economy and trades social protection to key groups and general investment in human development for political quiescence (Youssef 2004). The role of the state in Middle Eastern economies on aggregate as measured by the weight of government spending and employment in national economies supports this perspective. Until about a decade ago, government spending, which was about 25 percent of GDP at its peak in the 1970s and 1980s, far exceeded that of any other global region, including the OECD (World Development Indicators, various years).

A macro-level characterization of the Middle East as a highly interventionist region, however, obscures variation in authoritarian social bargains within the region. Even a division of the region into oil and non-oil economies does not do justice to the dynamics of welfare regime formation in the Middle East. Accordingly, many specialists further subdivide MENA countries according to their ideological orientations and corresponding development strategies (Cammett 2010; Grossman 2007; Henry and Springborg 2007; Richards and Waterbury 2007). For example, Richards and Waterbury (2007) classify MENA political economies as "socialist republics" and "liberal monarchies," which vary according to the rhetorical and to some degree actual importance of redistribution and public intervention in the economy.

The basic contours of welfare regimes in the Middle Eastern non-oil economies should be familiar to students of other regions in the Global South, especially of South Asia and sub-Saharan Africa. In general, formal welfare programs are limited both in terms of their eligibility criteria and scope of benefits. Health insurance schemes are largely reserved for government employees and a minority of formal sector workers, and private insurance markets are restricted. As a result, out-of-pocket spending is high and large segments of populations in rural areas and the informal sector, which accounts for the bulk of economic activity in most Middle Eastern economies, are not covered. Similarly, social insurance programs for pensions and unemployment, if they exist at all, are limited to formal sector workers and favor civil servants and military personnel. Public education and training programs are deficient and for decades have been perceived to be of inferior quality to private options. Consumer subsidies on fuel and basic foodstuffs are vital components of social safety nets across the region, as the history of "bread riots" across the Middle East attests (IMF2013; Sadiki 2000). Since the 1990s, in part due to the global diffusion of anti-poverty programs, governments have established various social funds targeting the poor with job creation and access to credit. A few countries such as Egypt and Morocco have experimented with conditional cash transfer programs.

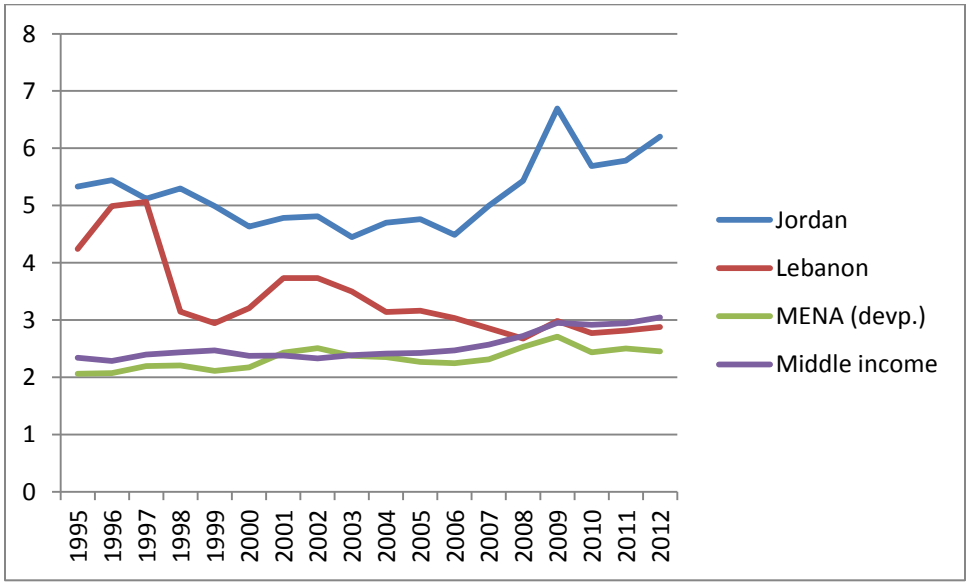
The underdevelopment of formal welfare programs increases the importance of informal mechanisms for assuring social protection. A large proportion of populations in Middle Eastern countries works in the informal sector – in some cases, over 50 percent of the workforce is employed informally – and families and kinship networks are integral to welfare systems. Remittances, informal credit channels, and agricultural portfolios of crops, livestock and family farm reserves are also vital. Religious organizations and charitable contributions and, increasingly, NGOs are also important providers and financers of social welfare in MENA countries (Karshenas and Moghadam 2006).

In this essay, I focus on Jordan and Lebanon as examples of two distinct types of welfare regimes among the non-oil economies of the Middle East. In these two countries, NSPs operate in very different contexts, whether in health, education, or other sectors. As a result, the extent, type, and operations of NSPs vary markedly in Jordan and Lebanon. In what follows, I provide background on the Jordanian and Lebanese welfare regimes, focusing on the health sector.

The Context of Non-State Provision: The Health Sectors in Jordan and Lebanon

What is the nature of the health system and how has the role of the state as financer, provider and regulator of health care evolved over time in Jordan and Lebanon? A cross-national comparison of public spending on health offers a preliminary snapshot of governmental priorities with respect to health. Figure 1 shows public spending on health as a percentage of GDP.

Figure 1: Government Spending on Health as a Percentage of GDP, 1995-2012

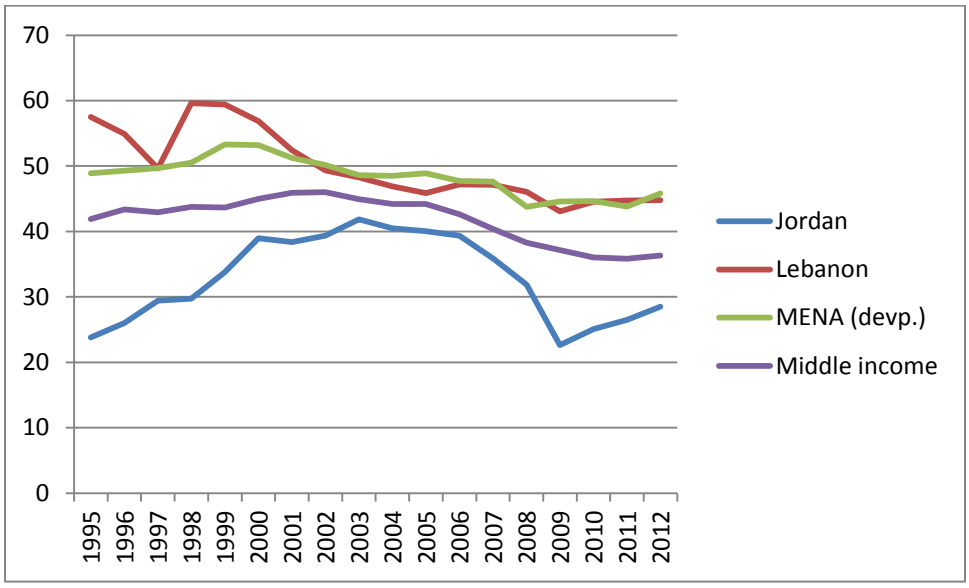


Source: World Development Indicators, various years.

Although data are only available from 1995, clear trends emerge that are corroborated by more qualitative assessments of health policies in these selected countries. The Jordanian government has consistently played a much more significant role in health financing than in Lebanon and, more generally, than in virtually all other non-oil Middle Eastern countries and than average levels in middle-income countries. By comparison, the government of Lebanon accounts for lower levels of health spending as a percentage of GDP.

These trends are generally mirrored in data on out-of-pocket spending as a percentage of total health spending. (See Figure 2.)

Figure 2: Out-of-Pocket Spending on Health as a Percentage of Total Health Expenditures, 1995-2012

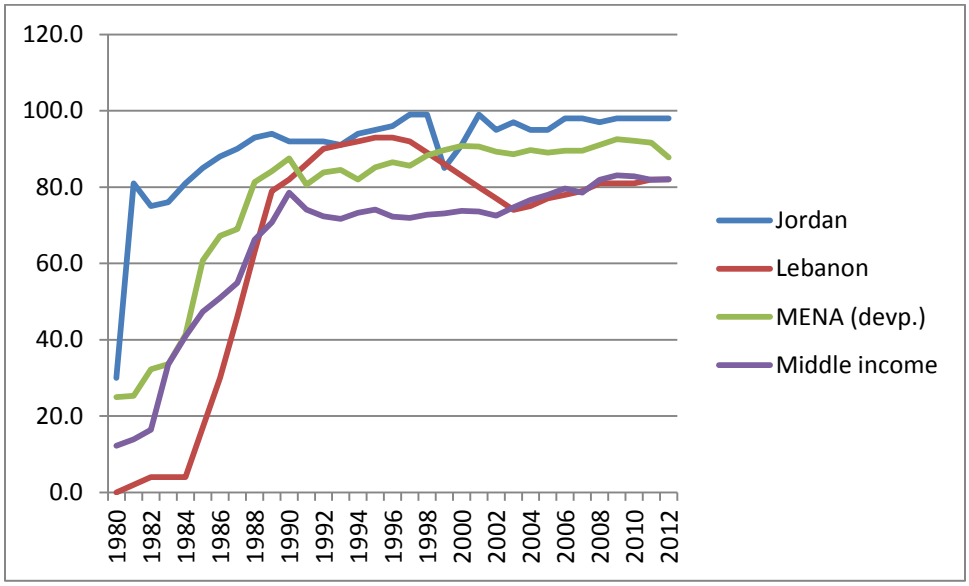


Source: World Development Indicators, various years.

Figure 2 shows that households in Lebanon pay more health care costs than in Jordan. Out-of-pocket spending in Lebanon has steadily declined from a high point in 1998, when public spending on health began to increase and non-state actors, including charitable providers, stepped up their role in health care financing and provision. In Jordan, however, household spending on health has declined even more sharply in roughly the same period. Out-of-pocket spending on health in Jordan is low in comparison with Lebanon and in comparison with the average levels for the developing countries of the Middle East and of middle income countries, as depicted in Figure 2. The comparatively high level of out-of-pocket spending in Lebanon places particularly heavy burdens on the poor, who are forced to spend a greater percentage of household income on medical costs than wealthier groups.

How do these data on national health spending patterns correspond with health outcomes? What levels of health do Jordanian and Lebanese citizens enjoy for the money that they and their governments spend on health? Here the limited comparative evidence presented below is mixed. Figure 3 shows DPT immunization rates across the same countries and country groupings.

Figure 3: Immunization, DPT (% of children ages 12-23 months), 1980-2012



Source: World Development Indicators, various years.

Levels of immunization rates as measured across the past few decades indicate that the more centralized and heavily public health system in Jordan has been able to reach children with vaccination campaigns more effectively than the more fragmented and privatized system in Lebanon. It is important to note, however, that Lebanon has experienced far more violent conflict on its territory than Jordan. The ensuing destruction of infrastructure and effects on the population have taken a toll on the Lebanese health infrastructure and capacity for public health outreach.

The data on infant mortality rates, which is generally regarded as a good proxy measure for the health and well-being of a nation (Reidpath and Allotey 2003), is virtually indistinguishable in the current period.

Table 3: Infant Mortality Rates (per 1,000 live births), selected years

	1970	1980	1990	2000	2010
Jordan	74	48	32	25	18
Lebanon	46	38	31	25	19
Middle East	128	88	56	39	27
Middle Income	99	77	61	49	38

Source: World Development Indicators, various years.

By 2010, Jordan and Lebanon had reached comparable levels of infant mortality – 18 and 19 per 1,000 live births, respectively – that both exceed the averages of Middle Eastern and middle-

income countries. That said, the decline in the infant mortality rate since 1970 has been much steeper in Jordan than in Lebanon.

A more nuanced picture of the role of the state and non-state actors in the two countries requires a more qualitative overview of the Jordanian and Lebanese health systems. How do NSPs fit into the welfare regimes of these two countries?

Jordan

With its consistent emphasis on the role of the private sector in the economy, the Jordanian monarchy has never espoused populist redistribution. Nonetheless, as the tables and figures above suggest, the Jordanian government has invested heavily in health and has ensured that citizens – and especially those of Transjordanian origin[1] – bear a minimal burden in fulfilling their medical needs in comparison with citizens in other Arab countries. The WHO characterizes the Jordanian health system as one of the most advanced in the region (EMRO 2006, 36). Since Jordan was established in 1943 as an independent state,[2] all national socioeconomic plans have emphasized the right to health and health care, and have even extended medical services to resident non-citizens such as the substantial Palestinian refugee population in Jordan.

As in all MENA countries, the security forces have always received preferential treatment with respect to health benefits (Baylouny 2010): In 1963, the first health insurance system in the kingdom was implemented to cover members of the armed forces. The resultant Royal Medical Services (RMS), which has its own health care facilities, caters to members of the military and their families and offers the most comprehensive package of benefits. Yet the general population, too, has relatively broad access to health services through a program and facilities run by the Ministry of Health, among other public and private institutions. Recent estimates hold that over 75 percent of the population enjoys health insurance coverage, although the extent of benefits varies significantly, with the most generous packages reserved for members of the military who are almost entirely of Transjordanian origin. A 2002 development plan called for 100 percent coverage by 2011 (Library of Congress 2006). Although this goal was not met by the stated deadline, universal coverage is currently a major policy priority for the government.

The provision and financing of health care in Jordan is based on a mix of public and private providers and donor institutions. Within the public sector, two major programs, managed by the RMS and Ministry of Health, finance and deliver care. Several other university-based programs in Amman, Irbid, and other big cities also provide health care. Established in 1953, the Ministry of Health is the single most important financer and provider of medical services in Jordan based on the size of its budget and utilization rates. Over time, its role in assuring public health has expanded. A royal decree issued in 2002 (Public Health Law No.54) declared that the ministry is responsible for providing and regulating public and private preventative and curative services. The facilities run by the Ministry of Health provide primary, secondary, and tertiary health

[1] Transjordanians refer to the "East Banker" citizens of Jordan whose families originate from the territory in the British Protectorate of Transjordan that lies to the east of the Jordan River rather than from the remaining portions of Palestine Mandate, parts of which Jordan controlled from 1948-1967.

[2] The country of Jordan is a colonial creation that emerged out of the Franco-British Sykes-Picot Treaty of 1916. In 1922, the League of Nations recognized it as the Emirate of Transjordan within the British Mandate for Palestine. In the 1948 War against Israel, Jordan captured what is now known as the West Bank, which it controlled until the Israeli occupation began in 1967. In 1988, King Hussein of Jordan official renounced Jordan's claims to the West Bank.

services and employ 25 percent of all practicing physicians in Jordan. Primary health care services are largely supplied through the ministry's network of 52 comprehensive health centers, 340 primary health care centers, 260 village clinics, and 353 maternal and child health centers. The Ministry also owns and operates 29 hospitals that comprise 37 percent of hospital beds and account for 43 percent of inpatient and 45 percent of outpatient care (EMRO 2006).

The Ministry of Health is also the largest financer of health care expenditures in the country, accounting for approximately 25 percent of total health spending in 2003. The government budget covers about 76 percent of the ministry's expenditures on health. An additional 11 percent of the ministry's expenditures on health are covered by enrollees of the Civil Health Insurance Program (CHIP), which was created in 1965 and covers individuals certified as poor, the disabled, children below the age of six years, and blood donors, who collectively account for about 20 percent of the population. The bulk of the ministry's budget covers the facilities it owns and operates, while about 17 percent of its expenditures were used to reimburse private and other public providers for services in the year 2003. The Ministry of Health is also effectively the insurer of last resort for the entire population, since any individual is eligible to receive the full range of services at its facilities at highly subsidized rates (15 to 20 percent of cost).

The private sector is increasingly important in both the financing and delivery of health care and its share of the health sector has grown markedly in the past decade. The portion of total health spending that accrued to private sector doctors and hospitals jumped from 48 percent in 2000 to 68 percent in 2010 (World Development Indicators, various years). Many Jordanians, including those covered by the public system, purchase private health services out of their own household funds. As of 2006, private hospitals accounted for 36 percent of hospital beds and about 70 percent of physicians. Jordan's Social Security Law No 19 of 2001 stipulates that private firms must contribute to health insurance for their employees through payroll taxes, but the law has yet to be implemented (EMRO 2006, 36, 40-42).

Unlike in Lebanon and many other Middle Eastern countries, in Jordan the public sector presides over a system that provides basic health care to all citizens at no cost or with heavily subsidized fees. In the past two decades, health inequalities and insecurity have grown and public finances are increasingly strained. Furthermore, preliminary assessments indicate that the quality of health care in public sector facilities is a serious concern.[3] Nonetheless, systematic measures of the quality of care in both public and private sector facilities has not been carried out and, in regional comparative perspective, the Jordanian health system offers relatively broad coverage.

Lebanon

The Lebanese health system is characterized by minimal state regulation and heavy reliance on private, non-state providers. The restricted role of public welfare institutions in part derives from the country's long historical experience of social organization along sectarian lines, which was further consolidated after independence through power-sharing institutions. Civil war from 1975 to 1990 consolidated the provision of welfare by sectarian groups as protracted conflict undercut the limited public health infrastructure constructed in prior decades and permitted the unrestricted growth of private health services. Between 1975 and 1991, the share of public hospital beds dropped from 26 percent to 10 percent of the total, and more than 50 percent of

[3] I am currently working on a collaborative project measuring the quality of care in the primary health sector in Jordan.

private hospital bed capacity was concentrated in high-cost curative care. After the war ended, the public sector continued to play a minimal role in the direct provision of health services, although it operates some hospitals and primary care facilities either on its own or in cooperation with non-state partners.

Multiple political parties and movements in Lebanon operate independent health networks, with their own hospitals, clinics, and dispensaries as well as computerized systems for maintaining medical records. For example, various agencies linked to the Shia Muslim Hezbollah operate four hospitals and at least 24 clinics while the Shia Amal Movement administers about 13 clinics and exerts de facto control over at least two public hospitals. The predominantly Sunni Muslim Future Movement effectively manages one public hospital and runs over 40 clinics through the affiliated Hariri Foundation Health Directorate, although some of its medical facilities have reportedly declined in the past several years. The weight of political organizations in health care far exceeds services provided in their own facilities: Because political parties use their connections to broker access for supporters to subsidies provided by the government or services offered by other non-state providers, their influence is broader than the number of health facilities that they administer directly. NGO-run health clinics and dispensaries, including those run by political parties, are critical for lower-income families in urban areas and may be the only facilities available in rural areas. Furthermore, differential access to politicians and government officials influences access to coverage for medical care.

In contrast to its minimal role in service provision, the government is a major source of health financing, particularly for secondary and tertiary care. In 2006, the public sector accounted for almost 47 percent of total health expenditures while out-of-pocket expenditures amounted to about 39 percent of health spending. Employers and donors supplied about 10 percent and 2 percent, respectively, of spending on health.

The vast majority of government spending on health goes to the public hospitalization program, which covers 100 percent of hospitalization fees until 1992 and 85 percent afterwards, as well as 60 percent of high-tech ambulatory services such as MRIs and CT scanners and 100 percent of cancer drugs. On paper, any citizen is eligible for these benefits. In practice, the program offers opportunities for personal discretion by ministry employees and enables political parties and religious authorities to obtain favors for supporters and congregationalists while claiming credit for these benefits. Moreover, because the government hospitalization program is in arrears, hospitals do not accept patients without demonstrated financial means or without vouchers from powerful political intermediaries.

As in Jordan and most other Middle Eastern countries, members of the military, civil servants, and formal sector workers rather than other categories of citizens benefit from insurance schemes. However, insurance coverage rates are far lower in Lebanon, where only about 50 percent of the population has any form of insurance, than in Jordan. This means that a significant portion of the population faces uncertain access to health care and has an incentive to seek services from charitable institutions, which are heavily controlled by sectarian political parties and religious charities, some of which have close ties with political groups.

This brief overview of the Jordanian and Lebanese health systems reveals the very different contexts in which NSPs operate: The public sector plays a far more dominant role in the health sector in Jordan, where health insurance coverage is more extensive and the government's primary health care network is more developed, notwithstanding reported problems with the

quality of care. Conversely, non-state actors, both charitable and for-profit, dominate the health system in Lebanon and the state's regulatory capacity is underdeveloped. Although some charitable NSPs appear to provide high quality services, the overall system is fragmented and a greater proportion of the population lacks insurance coverage.

The Experience of Social Rights in Jordan and Lebanon: Access and Accountability in the Health Sector

The distinct institutional and historical contexts that have shaped the development of welfare regimes of Jordan and Lebanon have varied implications for social rights. Building on the theoretical framework presented in the first part of this essay, I sketch out some preliminary observations about the dynamics of access and accountability in the health sectors in the two countries.

Access

On the one hand, access to services is relatively broad in both countries, particularly in comparison with other middle-income developing countries. Insurance coverage is more extensive in Jordan and, as a result, out-of-pocket expenses are lower than in Lebanon. But poor Lebanese also have the opportunity to seek heavily subsidized and sometimes even free services at the relatively extensive networks of charitable clinics run by an array of public and non-state providers. Thus, even in the more privatized context of Lebanon, low-income people can access health services.

On the other hand, the relative weight of the public versus the private sector in the health systems of these two countries shapes access to medical care, even when NSPs provide low-cost or free services. Depending on the type of NSP, discretionary considerations may mediate access to health services more frequently in Lebanon, where NSPs play a greater role in the health system, because eligibility criteria may be more restrictive. For example, as I show in other work, political organizations in Lebanon distribute social services and benefits selectively, with the most generous package reserved for core supporters (Cammett 2014). NSPs have no mandate to serve all citizens, although social norms often compel them to claim that they offer broad access to their services. Public providers, however, are obliged to serve citizens, even if only rhetorically. This legal obligation at least gives citizens a foundation on which to stake claims, even in authoritarian contexts.

Patronage and clientelism characterize the political economies of both Jordan and Lebanon, but the distinct public-private mix of welfare in the two countries means that informal politics operate differently, with distinct implications for the allocation of social services. In Jordan, access to the most comprehensive package of benefits varies largely along ethno-national lines. The military and civil service, which enjoy the most generous welfare benefits, are overwhelming staffed by Transjordanians. Jordanians of Palestinian origin are more heavily represented in the private sector, in which benefits are more uneven. In Lebanon, patronage and clientelism operate largely along political sectarian lines. This introduces far more discretion in the system and makes the foundation for social rights more ambiguous. In this system, people have access to rights via membership in a politico-religious community and, as I argue elsewhere, this is mediated by their publicly demonstrated engagement with political or religious institutions within that community (Cammett 2011, 2014).

In both Jordan and Lebanon, the health systems are fragmented, but their distinct public-private mixes of welfare lead to different manifestations of this pattern. In Jordan, the fragmentation of the system is most extensive with regard to the financing dimension of the health care system. Multiple agencies fund and administer the diverse components of health service delivery, leading to variation in the extent of coverage and access to services and permitting some households to benefit from multiple schemes. In Lebanon, however, the health system is even more disjointed. As in Jordan, multiple agencies are involved in financing different coverage schemes, but the fragmentation is also far more extensive with respect to the provision of health care services. As noted above, multiple charities run by the main sectarian parties and religious charities supply services through separate networks, which rarely coordinate their activities and are subject to only minimal public regulation. While it is usually possible for most people to obtain services in the end, the process of accessing them is all the more difficult and opaque when multiple providers with distinct eligibility criteria supply health care.

The distinct public-private mix may also affect the quality of social services*:* In both Jordan and Lebanon, public services provided by low-cost charitable providers are viewed as far inferior to those supplied by private, for-profit entities. To establish whether this is indeed the case would require systematic empirical research and should not be assumed ex ante.[4] In Jordan, the relative effectiveness of the state implies that the public sector has greater capacity to ensure that health care facilities adhere to quality standards. In practice, there appears to be little regular oversight over the delivery of services, even in public facilities, and patronage politics may result in overstaffing in health centers. However, the government has endorsed a well-designed and implemented health care accreditation program, which has induced significant improvements in the public clinics selected for participation since it was rolled out in 2011. Although the accreditation program is run by a non-governmental body, initially with donor support, the Ministry of Health and other government agencies have coordinated their activities and initiatives with the program, which has helped to ensure its apparent success.

In Lebanon, too, health facilities that offer low-cost or subsidized care, whether public or private, are perceived to offer inferior quality services. This is compounded by the fact that the weakness of state administrative and regulatory capacity undercuts the possibility of uniform oversight to ensure adherence to minimal standards for the delivery of care.[5] Paradoxically, the heavy role of NSPs in the health care system – especially those linked to political organizations – may create incentives for quality improvement, even in the face of deficient public stewardship. Some political parties seek to attract supporters through the provision of services, which compels them to boost the quality of their services to the extent possible. Nonetheless, as my current research explores, the goal of winning political support is not sufficient to promote the quality of service provision. Rather, sufficient organizational discipline, structure, and technical capacity must supplement a compelling mission – whether political, religious, or a combination of these and other factors – in order to promote high standards of medical care.

[4] I am currently engaged in two research projects designed to assess the quality of primary health care at the clinic-level in Jordan and Lebanon.

[5] Despite serious limitations on government effectiveness, in the past decade the Lebanese Ministry of Public Health has taken steps to improve the quality of health services in the primary health network, including the introduction of an accreditation program and the distribution of subsidized medications for chronic diseases to facilities that comply with certain basic standards.

Accountability

The distinct configuration of public and private institutions in the Jordanian and Lebanese welfare regimes also have implications for the accountability of providers to beneficiaries and the broader communities in which they operate. In Jordan, the relative effectiveness of the state creates the potential for enhanced accountability under the right incentives and institutional arrangements. State capacity to monitor and sanction NSPs, whether in relationships of co-production or domination, can boost NSP responsiveness to citizens. The top-down nature of the system and restrictions on social mobilization, however, restrict the scope for more accountable relationships to emerge between states, NSPs, and citizens. The health care accreditation initiative, which was initially conceived and funded by external donors and demands close coordination with Jordanian stakeholders, suggests one channel through which accountability can be enhanced, even in a country with heavy state control over politics and society. A key stipulation of the program entails the creation of local health councils, which bring together prominent members of the local community within each facility undergoing accreditation to aggregate and discuss important issues facing the community, conceive and launch special events and health awareness campaigns, and serve as a channel between the beneficiaries and administration of the health center. At least some of these committees have become effective actors in their own right and appear to have tangible, positive effects on health outcomes. For example, the local health committees sometimes launch initiatives to screen community members for chronic diseases and to educate them on how to care for themselves. As a result, testing and treatment for conditions such as diabetes and hypertension have increased in these areas.

In Lebanon, where the welfare regime is far less centralized, the multiplicity of delivery and funding streams of social services has made it difficult for citizens to hold providers, funders, and the government accountable for service provision. Although the competitive environment may compel some NSPs to be more responsive to clients, on net non-state provision in Lebanon either reduces the accountability of providers to citizens or, at a minimum, renders accountability mechanisms more complex. In characterizing state-NSP relations in Lebanon, the country represents a clear case of "appropriation," in which NSPs take credit for state funded or supplied services, and in some regions verges on "substitution," in which NSPs take over aspects of service delivery where the state is virtually absent. In this context, providers have a vested interest in underdeveloped state regulatory capacity, compelling them to block efforts to enhance state monitoring of their activities and restricting potential channels that might induce them to increase their responsiveness to communities.

Conclusion

In recent years, the non-state provision of social welfare has been consolidated or has increased in many developing countries. This trend has even touched countries with the greatest public sector involvement in their welfare regimes in the Middle East, such as the oil-rich countries of the Gulf region, as well as countries with deep legacies of statist developmental models, such as Egypt. What are the ramifications of non-state provision for key aspects of social rights, including access to social services and the accountability of providers to the communities they serve? The answer to this question is not simple: The impact of non-state welfare provision on social rights varies by the type of NSP, its relationship to the state, and the capacity of the state to regulate the provision of welfare at the local level.

Focusing on the health systems in Jordan and Lebanon, which vary in their public-private mix, I trace the implications of their distinct configurations of health care financing and provision for the experience of accessing medical care, particularly among those who cannot afford to pay for private medical services. Preliminary observations based on ongoing field work on health politics in Jordan and Lebanon suggest that most dimensions of access and accountability are enhanced in the more centralized and state-controlled health care system in Jordan. When providers at least theoretically have a mandate to serve all and the state has greater capacity to regulate the provision of services, the experience of seeking, obtaining, and providing feedback on health care is more straightforward. A different dynamic may hold with respect to access to high quality medical care. In both Jordan and Lebanon, public facilities have a reputation for poor quality. In Lebanon, where NSPs run most primary care centers, competitive relationships between the parent organizations of some of them creates incentives for them to maintain or improve the quality of care in the social welfare institutions. These initial reflections point to an important and relatively uncharted research agenda on the political and organizational determinants of quality in service delivery.

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