INTEGRATED SOCIAL POLICY

Towards a New Welfare Mix?
Rethinking the Role of the State, the Market and Civil Society in the Provision of Social Protection and Social Services

Report V

V

ESCWA

United Nations Economic and Social Commission for Western Asia

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When the long-simmering social crises in Arab countries erupted to the surface in 2011, these events immediately shifted government attention from the economic to the social field. Suddenly it became clear that years of substantial economic growth had not improved social outcomes and Governments rushed to increase public employment and wages, improve services, increase social transfers and invest in social infrastructure.

However, Governments and societies are aware of their need to find more sustainable ways to solve structural socioeconomic as well as political problems. Changes in the policy sphere may open the way for a different approach to social development that will be more inclusive of people of all ages, regions and income groups and grant more equitable access to social protection and social services.

The present report explores the prevailing welfare mix in Arab countries, the contribution of different private sector enterprises and civil society actors to social protection and social services, and the advantages and difficulties emerging from the current situation. It does not aim to provide a comprehensive inventory but rather looks at issues such as education or health-care services on the basis of examples from selected countries.

The report was jointly written by Ms. Gisela Nauk, Chief of the Social Policy Section at the Economic and Social Commission for Western Asia (ESCWA) and Ms. Vanessa Steinmayer, First Social Affairs Officer in the Social Policy Section. It is broadly based on background research conducted by the following experts: Ms. Allison Minor, Ms. Emilie de Keyzer, Mr. Giulio Ferraresi, Ms. Katharine Brooks; Mr. Manuel Buesser, Mr. Mohammad Yousif, Ms. Monique Morisse and Ms. Rasha Jarhum.

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Feedback from readers would be welcomed, and comments and suggestions may be sent to sps-escwa@un.org.

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ACRONYMS

CRPD	Convention on the Rights of Persons with Disabilities
DPO	Disabled Persons' Organization
EFE	Education for Employment Initiative
ESCWA	Economic and Social Commission for Western Asia
GCC	Gulf Cooperation Council
GDP	gross domestic product
GUVS	General Union of Voluntary Services, Jordan
HAAD	Health Authority of Abu Dhabi
HIO	Health Insurance Organization, Egypt
ICCS	Islamic Charitable Centre Society, Jordan
IDP	internally displaced person
ILO	International Labour Organization
ISSA	International Social Security Association
LDCs	least developed countries
MICS	Multiple Indicator Cluster Survey
MDGs	Millennium Development Goals
NAF	National Aid Fund, Jordan
NGO	non-governmental organization
NHRA	National Health Regulatory Authority, Bahrain
NPTP	National Poverty Targeting Programme, Lebanon
NSSF	National Social Security Fund, Lebanon
OECD	Organization for Economic Co-operation and Development
PAYG	pay-as-you-go
PISA	Programme for International Student Assessment
TIMSS	Trends in International Mathematics and Science Study
UAE	United Arab Emirates
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
USAID	United States Agency for International Development
WDI	World Development Indicators
WHO	World Health Organization

GLOSSARY OF KEY TERMS AND INDICATORS

Civil society	Social groups seeking to advance common interest, usually out of common values that can emanate from religious beliefs, political goals, purely charitable goals or a combination of several goals.
Faith-based organization	Broadly defined, subsuming all organizations that use or promote elements of their faith in their operations; organizations that are, among other reasons, driven by their faith and often draw large parts of their funding from donations that people make out of their faith.
Informal sector	Activities and income that are partially or fully outside government regulation, taxation and observation.
Labour force	The sum of the number of persons employed and the number of unemployed (individuals without work who are available for work and looking for work).
Labour force participation rate	The proportion of a country's working-age population (normally above 15 years of age) considered part of the labour force; it provides an indication of the relative size of the supply of labour available to engage in the production of goods and services.
Out-of-pocket health expenditure	Any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services, whose primary intent is to contribute to the restoration or enhancement of health status. It is a part of private health expenditure.
Private education	All educational institutions that are operated by institutions other than the state.
Private health expenditure	All health expenditure from private sources, including expenditure for private health insurance.
Private sector	Non-state actors that work with commercial goals, aiming to make profit or achieve cost coverage.
Public sector	The part of a country's economy which is controlled or supported financially by the government.
Regulatory capacity	A country's capacity to pass coherent and transparent rules, and to monitor and enforce compliance with these rules.
Rights-based approach	A view of social protection in which human rights determine the relationship between individuals and groups with valid claims (rights-holders) and state and non-state actors with correlative obligations (duty-bearers). It identifies rights holders and their entitlements and corresponding duty bearers and their obligations, and works towards strengthening the capacities of rights holders to make their claims, and of duty bearers to meet their obligations. All individuals are equal as human beings and by virtue of the inherent dignity of each person. All human beings are entitled to human rights without discrimination of any kind, such as race, colour, sex, ethnicity, age, language, religion, political or other opinion, national or social origin, disability, property, birth or other status as explained by the human rights treaty bodies.

Social protection floor	Nationally defined sets of basic social security guarantees that should ensure, as a minimum, that, over the life cycle, all in need have access to essential health care and to basic income security, which together secure effective access to goods and services defined as necessary at the national level.
Waqf	A religious endowment where the donor gives away some of his or her wealth and determines the purpose and beneficiaries of the endowment.
Zakat	A levy on wealth, which is a religious obligation in Islam and one of the five pillars of Islam. It varies by wealth position, but is roughly 2.5 per cent of capital assets.

EXECUTIVE SUMMARY

Welfare systems in Arab countries are at their limits. Stretched by substantial population growth over the past years, the Governments are increasingly unable to integrate all people from all ages, all regions and all income groups into the labour market and into social protection schemes. After initial years of development progress, the accessibility and quality of public social services declined significantly and failed to meet people's expectations.

At the same time, solid economic growth over the past decades and development achievements in the areas of health and education have nurtured the emergence of a new middle class, whose aspirations to upward social mobility, better economic chances and productive integration into society were largely thwarted.

The two trends together exposed the limits of States to exert their role of guarantors of human and social rights as enshrined in many Arab constitutions, and as expected by their citizens. States are challenged simultaneously on the social and economic fronts. The current urge for increased social protection comes at a time where the fiscal capacity of the public sector is restricted. Although public social spending is substantial, a big part of expenditure flows into subsidies and universal services, which makes it difficult to establish distributional effects.

Moreover, a multitude of non-state actors are engaged in the social sphere, often providing essential services to the population. While their involvement certainly increases the coverage of the population and improves their access to social services, such diversity of actors also entails the risk of fragmentation. Unless the quantity and quality of services are well regulated and coordinated, inequalities may go unnoticed and not be addressed.

The present report explores a number of questions related to the "welfare mix" of social protection and services provided by different actors in Arab countries. The main questions are as follows. How efficient is the current welfare mix? Who are the main actors? How are they coordinated? How effective are they in ensuring social protection for the entirety of the population?

Chapter I presents a brief review of the historical evolution of welfare systems, their constituent institutions and the main mechanisms employed by the state to equalize costs across social groups. It argues that welfare systems are normally embedded in the political economy of their respective societies, and that political change may open the opportunity to broaden social protection coverage and access to basic services as advocated by the Social Protection Floor.

Chapter II looks at the ways the public sector typically organizes the provision of social protection and social services. It concludes that the impact of social protection programmes on poverty is rather limited due to high expenditures, especially on fuel subsidies, as well as high fragmentation of social assistance programmes and poor targeting. About 70 per cent of the people in the poorest quintiles of the population do not receive public transfers. Public education and health systems often fail to deliver the expected results and may also be weakened by corruption.

The chapter concludes that insufficient public welfare provision leaves behind two types of gaps. Quality gaps result from insufficient quality of public services, which do not meet the expectations of citizens and do not support the formation of human capital. Quantity gaps result from insufficient coverage of the population, especially insufficient outreach of public services into rural and poorer areas.

Chapter III argues that private sector provision of social services has been growing and describes the form it has taken in Arab subregions. The countries of the Gulf Cooperation Council (GCC) have engaged the private sector very systematically, mainly to fill quality gaps in health and education, or to provide insurance and social services to foreign migrant workers. This strategic approach goes hand in hand with relatively clear regulation. In other countries, the private sector is spontaneously filling niches and service gaps. In the countries affected by conflict such as Lebanon, it reacted to the collapse of the state, providing services in times of crisis. In other countries it responds to the demand of the elites for better quality services. State regulation in such situations is often less developed. If not properly regulated, and if access is based exclusively on the ability to pay, an over-reliance on private services may exacerbate unequal access to good quality services, especially if the population is not covered by insurance that would take over the costs. The private sector, to a certain extent, is able to compensate for public sector quality gaps, but only for specific population groups who are able to pay for the services. It also does not cover all existing needs, as private insurance or private pension plans are not widely used.

Chapter IV looks at the diverse spectrum of civil society providers of social services and social assistance. The biggest providers are religious institutions like zakat funds and faith-based organizations. Many organizations provide services through their own networks of schools or hospitals, and they also provide funds to individuals or groups to buy such services from other providers. Other civil society organizations are more fragmented. They may be associated with influential political figures and often produce very specialized services, e.g. for persons with disabilities.

Civil society is able to fill certain gaps, but it suffers from weaknesses similar to those seen in the public sector such as high fragmentation, underfunding, duplication and insufficient targeting. From a rights-based perspective, civil society services are more accessible than private sector services and are often of better quality than services provided by the public sector. However, when it comes to servicing the poorest population, civil society is not the most reliable source – partly by design, but partly also because of insufficient funding.

Chapter V summarizes the discussion and highlights the following points:

- The combined effects of high population growth and increasing demand of the population for more and better social services have brought social welfare systems to their limits. Systems were overwhelmed by demand, which resulted in sizable coverage gaps, leading to increasing 'welfare dualism', or the polarization of societies in terms of income and human capital.
- Non-state actors are able to partially alleviate the situation and to fill in some of the gaps, but only under certain conditions. They must be regulated by the state in a way that ensures certain quality standards, as well as equity and equality of access - especially in situations where non-state institutions are the only source of social protection and services.
- Governments may choose to conduct a comprehensive review of their welfare system in order to identify the main strengths and priorities of the public sector. In many countries, such a review could reveal pathways to improve the quality of basic services in health care and education, comprehensive

income security for children and the elderly, as well as assistance to the poor and unemployed. Such an approach corresponds to the social protection floor, advocated by the United Nations.

- Ideally, a comprehensive review would also enable Governments to pursue a defragmentation of public services, and a consolidation of programmes and financing streams. This entails reforming social insurance programmes and pension funds, which often are segmented according to occupational groups. Consolidation might allow Governments to better expand social insurance to unprotected groups.
- Governments should prioritize the establishment of a social policy infrastructure that is able to reach out to all geographic regions and social groups. After identifying a limited set of social policy priorities, the public sector should develop clear policy objectives, pool available funds and assign clear tasks to possible partners in the private sector and civil society.
- Regulatory capacity is often undervalued. Good regulation of the activities of non-state institutions requires administrative capacity and skills, which are not always available in public administrations of Arab countries. The ability to formulate, enforce and monitor clear and transparent regulation is a key competency of a well-structured state bureaucracy. And it is as important for a well-functioning welfare system as it is for economic development.
- Quality standards for social services are often insufficiently defined in Arab countries. This is a difficult task, since social outcomes usually result from a mix of individual, social and institutional conditions. However, Governments could do more to ensure that facilities are adequate, and that education and health personnel are well qualified, behave ethically and exercise due diligence in the execution of their duties.

Introduction

INTRODUCTION

In January and February 2011, when countries in North Africa toppled their Presidents, Governments at the other end of the Arab region increased public sector wages and consumer subsidies and created public sector jobs on a larger scale. Generous cash transfers, housing projects and investment in other social infrastructure made it clear that Arab Governments interpreted public discontent as a result of a social crisis, which they strived to subdue through social handouts.

The public call for dignity and social justice underscored that the people who took to the streets indeed regarded social problems as one of the main motivations to demand political change. High unemployment and low wages threaten social security, and the exclusion of large social groups from quality social services limits their human capital formation and obstructs their chances to live in dignity and to be free from poverty.

It suddenly appeared that years of significant public expenditures on social transfers, subsidies and public services across the Arab region had either missed their target or had failed to prevent a social crisis. As a share of gross domestic product (GDP), spending on subsidies and social transfers in Arab countries is, on average, more than double that of other developing countries, yet this is not reflected in social outcomes.

Recent developments in the Arab region have thus raised a number of relevant questions. What are the gaps in welfare systems? How are welfare systems currently organized in Arab countries? How far do they reach and serve the people most in need? Which institutions are involved in welfare production and how are they coordinated? These are the main questions guiding the report. The objective is not to provide a comprehensive inventory of social policies, but to review the actors engaged in the production of social welfare.

The report takes a systems approach to social welfare, and looks at the provision of social protection and social services from a rights-based perspective on quality, equity of access, coverage and sustainability of services. It highlights the most salient features of the existing "welfare mix" in Arab countries, the kind and level of social welfare that is produced as a result of the combined activity of all actors. The report identifies research and knowledge gaps and draw preliminary conclusions and recommendations.

Standing within the context of the series of publications of the Economic and Social Commission for Western Asia (ESCWA) on integrated social policy, which advocates for policy harmonization across

various domains and for mainstreaming social and equity concerns, this report reviews key policies, brings together a preliminary review of facts and issues involved and underlines the need for further research.

Methodologically, the report is based on several background papers on private sector provision of social services in Arab countries and the social welfare activities of non-governmental organizations (NGOs) and faith-based organizations, in addition to selected field studies of religious institutions such as zakat funds or *awqaf*. This report is also the result of systematic monitoring of social policy interventions of Governments in the region over the past two years, during times of political change.

Chapter I

I. WELFARE POLICIES OVER TIME

When thinking of social welfare, one tends to look at the state. The state is regarded as the guardian and protector of its citizens and the guarantor of their social rights as enshrined in constitutions and international conventions. A recent survey carried out in Egypt, Jordan, Lebanon and Tunisia showed that 90 per cent of people see the state as the main provider of social security,[1] and they expect it to play an equalizing role in access to education, health care and other social services.

However, social policy existed before the emergence of the classical 'welfare state', and welfare has always been more than publicly provided welfare. What we understand as the 'welfare mix' actually represents an interplay of different institutions, which has led to an increasing tendency to talk of 'welfare systems' instead of 'welfare states'. In welfare systems, all institutions together produce the welfare of citizens and include the family, the community and charitable networks, the market or commercial providers, and the state. In developing countries, this group of actors may need to be enlarged to include international organizations.

All the different actors come with different strengths and limitations, which relate to their capacity to do the following: (a) protect people against lifecycle risks such as illness, old age, injury and unemployment; (b) provide high quality services in the areas of health, education and employment; and (c) reach out to the people most in need.

This chapter looks at the institutional landscape that constitutes the 'mixed economy of welfare'.[2] It traces some of the paradigm shifts that occurred over the past decades, outlines the main distributional effects of different social policy instruments, and introduces and discusses the characteristics of some groups of actors. It concludes with observations about welfare policy in developing countries, underlining the importance of the social protection floor.

A. The changing role of the state in social policy

Around the globe, welfare systems are conceived in very different ways, and the mix of the different actors, the degree of their involvement, and the role of the state in the delivery of social protection and social services often changes over time.

The central role of the state in national reconstruction and development after the two world wars in the early twentieth century reflected a shared appreciation of social solidarity that emerged from common destitution, and a deep distrust of markets as a consequence of the global economic crisis of 1929. Programmes

like the New Deal in the United States (1935), the Social Security Act of New Zealand (1938) and the Beveridge Plan of Great Britain (1942) culminated in the Declaration of Philadelphia of the International Labour Organization (ILO) in 1944. In 1948, the right to social security was included in article 22 of the Universal Declaration of Human Rights.

State-led industrialization through import substitution in Latin America was strongly supported by social and labour movements, which played an important role in the design of welfare states in that region. Social security systems expanded to cover workers in the best organized and strategically located sectors of the middle and working classes, particularly the mining and manufacturing industries, and to public employees.[3]

East and Southeast Asian 'developmental states' regarded education and health care as important instruments to build up a skilled workforce needed to carve out an economic niche in the world market. Social investment was an integral part of the modernization process, even though social safety nets remained limited in scope until the late 1990s.[4]

In the Arab region, contributory systems of social insurance were established beginning in the 1950s in Egypt and Iraq, and continuing through the 1970s in monarchies. Public health-care provision and infrastructure were expanded. Public education, especially, was considered important for the formation of a skilled bureaucracy after independence. Most countries also introduced indirect social transfers in the form of subsidies for essential commodities or services such as food, electricity, fuel, housing and so on.

These welfare systems, introduced during the post-war economic boom period, ran into crisis in the late 1980s. Faltering global growth rates exerted pressure on public budgets and led to an ideological debate about the role of the state in the social sphere. Instead of compensating for unequal market outcomes through redistribution, the state was now more oriented towards creating an enabling environment for its people to pursue their individual chances and careers. Grass-roots initiatives and NGOs claimed to be better able to respond to the concerns of citizens and to work more cost-efficiently than the distant and bureaucratic state. Throughout the world, NGOs and civil initiatives aspired to fill the vacuum of failing public services. From there, the international discussion crystallized in two main directions: market-based and rights-based.

The market-based discourse emphasized that competitiveness in the global market was the main deciding factor for national economic and social development prospects. While the forces of globalization can constrain national social policy, they were successfully reducing poverty and income inequalities on a global scale: a global market-based resource allocation mechanism would facilitate direct investments and attract financial resources to emerging markets of a magnitude that no national strategy would be able to mobilize. The main role of governments was to provide sound institutional frameworks and an enabling rules-based environment. The privatization of public utilities, the private sector provision of education and health-care services and the increased involvement of the private sector in social insurance schemes were regarded as a way to relieve the strains on public budgets, and to increase the quality and efficiency of social services.

The rights-based discourse sought to counter the strong economic focus of the liberal school of thought with an emphasis on human development. Human security is held up as an essential part of the social contract that cannot be subject to global economic competition.

Investing in people is essential not only to modernize and develop a country, but also to achieve social cohesion and political stability. The responsibility of the state stretches far beyond the provision of a sound legal framework: it must ensure equal opportunities and fair social outcomes. A discussion over 'stakeholder' versus 'shareholder' value sought to bring the social perspective into markets that are driven by the quest for ever-higher profit margins.

A turning point occurred during the recent global financial, food and fuel crises. Concerns about increasing economic imbalances and weak institutions with too little capacity to regulate global markets and social outcomes made the public sector and overall institutional governance a prominent focus for policy reforms. In addition, economic research indicates that highly unequal income distribution and high vulnerability or poverty rates may negatively affect the medium- and longer-term growth potential of economies. A large middle class may positively impact economic growth and redistributive policies may actually benefit overall economic efficiency.[5] By equalizing opportunities through broader access to health and education, countries can improve their overall resource endowment and trigger important productivity gains, provided that policies and institutions are constructed accordingly.

B. Institutional arrangements

The capacity of states and societies to balance inequalities, to provide the right quantity and quality of social services and to distribute outcomes depends on the institutions and the design of the policy instruments as much as on the overall resource envelope. Depending whether the objective is the equalization of income, of social outcome or of social and economic opportunities, a certain mix of institutions and instruments may be preferable to other possibilities.

1. Social security

Market-based instruments such as individual savings accounts with commercial banks, but also commercial life insurance, establish a direct link between present savings or contributions and future benefits. The effect is an *inter-temporal equalization* of income streams between an individual's present and future earnings, without interpersonal redistribution of any kind. For that reason, individual inter-temporal equalization is not regarded as a social security instrument. However it can play an important role in the overall welfare mix – especially in situations where the state is weak.

Other types of private insurance, such as health insurance and insurance against commercial risk, are based on solidarity principles, where all participants contribute to a common fund, from which they can draw compensation. In this case, the common contributions are *equalized horizontally* and are redistributed among all who participate in the fund. Insurance companies influence the degree of redistribution through the criteria for participation. Selectivity based on the risk propensity of the participant can help to keep contributions low.

In contrast to private insurance, social insurance systems are marked by a lower degree of selectivity. They accept participants who are more prone to risk, namely poor people who face harder working conditions, and so the interpersonal equalization of the system may also include *vertical redistribution* from richer to poorer participants. Pension funds that are constructed according to the social insurance principle are indicative of interpersonal, vertical and *intergenerational equalization*, where the contributions of current workers are paid out to current pensioners.

Vertical redistribution mainly occurs in direct or indirect cash transfers, which are financed by general government revenues rather

than contributions. The transfers are either made directly by the government or through government-monitored civil society organizations contracted for this purpose. The success of vertical redistribution largely depends on the quality of the policy infrastructure, specifically the institutional channels through which the funds are transferred. It also depends on government capacity to identify those most in need of assistance and reach the most vulnerable social groups.

2. Social services

In addition to these instruments of insurance and social insurance, social services, especially health, education and water supply, are decisively influencing social outcomes, particularly the equalization of opportunities across social groups. Again, the mix of private or public provision of social services, the engagement of civil society institutions, the regulation and monitoring of the adequacy and quality of service determines whether all social groups have equal access to quality services.

Public education systems are often run free of charge at the primary level and often at the secondary level, in order to encourage broad-based education that generates a more productive workforce. Free tertiary education, however, tends to benefit the middle class. Middle class children are able to pursue a longer period of education because their families are less likely to depend on their contribution to household income. The welfare mix of countries with a high share of private schooling at the primary level and, at the same time, free university education would thus benefit the urban middle class more than those who are poorer or who reside in rural areas.

Similar effects can be observed in health care. From an equity and efficiency perspective, a well-equipped public network of affordable primary health-care services in rural and urban areas is more important than specialized high-technology hospital services in the capital city, which are unlikely to be used by urban slum dwellers. Cost-intensive and high-technology health-care facilities may be more effectively provided by the private sector, especially if costs are covered by a well-designed social health insurance system.

Some countries maintain a broad-based public health-care system, financed entirely from general government revenues, and provide the services either free of charge or against a minimal fee (Beveridge system). Others combine a largely private care infrastructure with an extended system of social health insurance funds, which draw contributions from employers as well as employees and may be co-funded by the government (Bismarck system).

Advantages of the Beveridge system have long been seen in its universalism and its principal ability to provide services to all citizens independent of their employment and social status. In contrast, the Bismarck system is largely employment and contribution based and, if not subsidized by the government, tends to exclude the unemployed and the self-employed. The inherent dualism of insiders and outsiders is especially disadvantageous in countries with large informal sectors, where persons outside the formal sector are not registered with the health insurance and may incur high out-of-pocket payments for private health-care services.

Depending on the overall welfare mix, countries may run the risk of developing dual standards of service provision. A general shortage of public funds and a lack of political will may result in public health-care and education systems that provide only minimal services of insufficient quality. As a consequence, people who can afford to do so are paying for higher quality private education and health-care services. To compensate for gaps in the quality of public services, some private employers may also offer supplemental health insurance for their employees.

C. The political economy of welfare

'Welfare dualism' is the division of societies into groups of insiders and outsiders. Insiders are those social groups that are reasonably covered against life cycle risks and can access social services in adequate quality, while outsiders are excluded from social security systems and have to resort to social services that are unreliable or of lower quality. Welfare dualism is the most fundamental challenge of welfare systems, and the challenge is not limited to developing countries.

The decision of how widely coverage is spread, or the dividing lines between the social groups that are included or excluded, is often the result of political and economic power relations within given societies, the so-called political economy. In this perspective, the characteristics of the social-democratic 'Nordic welfare system' resulted from a political alliance between organized labour movements and farmers' movements, the 'red-green alliance'.[6] In contrast to other cases where strong labour movements pushed for mainly employment-based social insurance systems, this coalition of the employed with mostly self-employed farmers resulted in a universalistic welfare system, where all citizens are endowed with similar rights independent of class or employment position.[7]

Welfare systems tend to strengthen and reproduce the conditions on which they are built. Conservative welfare states, for example, originating from societies with a strong emphasis on status and privilege, tend to reinforce the differences in social status between civil servants and other groups of state employees by establishing separate insurance schemes with different rights and entitlements. Social assistance programmes are set up for those outside of the formal labour market. Such forces of stratification deepen the existing segmentation of the labour market, reduce labour mobility and reinforce the division of society into well-protected insiders and outsiders who either go without social protection or have significantly reduced access to social security and social services.

The problem of exclusion is especially acute in many developing countries (especially in developing middle-income countries) because large parts of the population are engaged in the informal sector. In Latin America, for example, before the recent reforms of more left-leaning Governments, welfare states were 'deep, but not wide', meaning that the state spent substantial resources on social security, but coverage was limited and access was often highly unequal.[8] East Asian welfare states that were rather minimalist until the late 1980s invested heavily in an expansion of the social infrastructure and entitlements after the Asian financial crisis, but still have not adequately covered larger parts of the population, especially in the informal sector. Arab countries face similar problems of dualism and exclusion (see chapter II).

D. Welfare organizations beyond the state

In many countries, the combination of welfare dualism, limited coverage of formal social security systems and insufficient quality of public education and health-care services lead to a situation where societies are divided not only into income groups, but also in terms of their human capital.

This raises the question whether excluded groups have other ways to satisfy their needs. What are the alternative institutions to help poorer parts of the population cope with risks, provide their children with good quality education and care for their health? How reliable are they? What is the particular strength or advantage governments may wish to harness through partnerships that formally integrate them into the welfare mix in order to broaden access and coverage?

1. *The family*

The basic source of welfare in any society is the family. Its strength lies in the personal nature of care, and the services it provides are often connected to strong emotional bonds. As families are bound by moral ties, many people regard them as the most reliable providers of care services. Family support is especially valued in a traditional Muslim context, where transfers between members of a family (and extended family) are seen as important components of intergenerational support, which may involve financial transfers but also non-monetary care services. However, as family support predominantly takes place within a single social group, it may deepen rather than alleviate social inequality and exclusion. The informal nature of family support and care, and its independence of conventional market prices, leaves very little quantifiable information on the volume and value of such support.[9]

In recognition that families are an important source of social welfare, Governments often provide subsidies and allowances that can positively influence the social situation of beneficiaries. Conditional cash transfers provided to families if, for example, children attend school or regularly see a doctor, integrate family care into the broader social policy framework and can thus positively influence not only the income distribution but also the formation of human capital.

2. *Civil society*

Civil society and non-profit organizations are often seen as a response to state and market failures alike, providing public goods in situations where the state is not able or not willing to provide, and where commercial provision of such services is either not viable or not desirable.[10] For example, the *gama'iyyat*, which are rotating savings organizations, are the most common community-based organizations in Arab countries; they support the accumulation of savings especially in areas with limited access to the formal banking system.

Civil society organizations based on distinct communities, private foundations and charities largely correspond to the same logic. Charities rendering support and services to the poor are funded through donations, which would not be given to for-profit enterprises. Care institutions, schools and hospital are often run by commercial non-profit organizations, which operate on a cost-recovery basis. They may also receive subsidies or tax exemptions by the state, which would not be granted to profit-making enterprises. Chapter IV discusses salient examples of services provided by NGOs, including their limitations.

The delineation of for-profit organizations on the one hand and governmental service provision on the other hand is not always clear. In this report, the Islamic institutions of zakat and waqf are counted as civil society institutions, as they are often administered through mosques or through separate institutions. However, as will be elaborated in chapter IV, in several countries zakat is levied as a general tax and treated as a special part of overall government revenues.

Similarly, the term 'social entrepreneurship' illustrates the substantial overlap between commercial non-profit and commercial for-profit enterprises. It denotes activities that are geared towards achieving a positive social impact, but may come in different legal forms. They may operate as non-profit, as hybrid and for-profit enterprises but are bound together by social values, principles and a commitment to sustainable practices. The rise in private philanthropy in the Arab region may be related to a retreat of the public sector and the insufficient response of the private sector to social development problems. Calls for a new development framework encourage more

innovation and strategic approaches among philanthropic organizations in the region.[11]

In terms of social policy, the effect of community and civil society welfare may be very positive. Charities may help to cope with risk (although they cannot offer protection) and also effect some vertical redistribution from richer to poorer people. Services can be tailored to the cultural identity and needs of small communities, and they may also be faster in responding to emerging needs and in reaching especially vulnerable people like persons with disabilities or refugees. Social entrepreneurs may equally respond to emerging needs.

However, unless long-term funding is secured, civil society welfare may have limited redistributive effects and may not be able to influence long-term human capital formation. In many cases, the nature of civil society welfare is humanitarian rather than being a stable social policy institution.

The nature of civil society welfare can change, however, if governments enter into official partnership with civil society organizations in order to harness their flexibility, skills and response capacities. Such partnership can enhance the financial stability of civil society organizations, integrate them into the overall social policy framework, and also allow the state to monitor the quality and adequacy of the services provided.

3. Market-based providers

Market-based services include various commercial savings and insurance products that allow people to build up reserves for hard times, either through simple savings accounts or through participation in risk-pooling insurance funds. As mentioned above, private insurance companies may be highly selective and reject prospective clients who are prone to risk, or they may charge a high premium, which poorer people cannot afford. Nevertheless, if well regulated, they are an important component in the welfare mix.

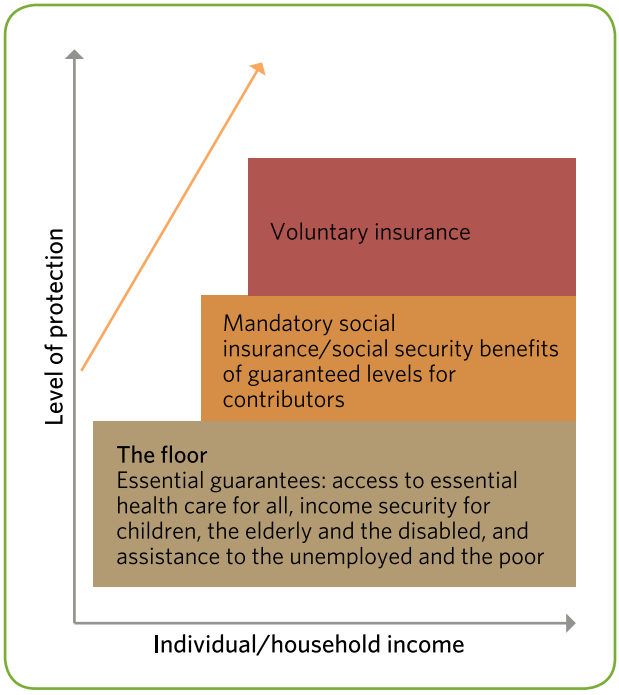
Other institutions include commercial service providers that are active in the health-care and education sectors, and are increasingly active in the operation of water and electricity companies. The advantage of commercial actors lies in their ability to mobilize larger resources for costly, advanced technologies, for example in health care or water infrastructure. Also, private companies are often regarded as more efficient and cost effective and, as they have to compete for their clients, they may offer services of better quality.

The benefit of private providers, especially of health and education, fundamentally depends on the quality of the service. Quality assurance, however, in education and health-care services is hard to establish, and government regulation and monitoring is difficult. Formal contractual relations between the government and private companies (public-private partnerships) can spare the government large investments and offer the opportunity to attract advanced technology and know-how. The overall social benefits, however, largely depend on the capacity of public administration to shape contractual obligations in a way that balances private and public interest, and to adequately monitor operations.

E. The rights-based approach and the social protection floor

While these actors can play an important part in the overall welfare mix, it is important to ensure that they do not perpetuate or deepen welfare dualism, but support an expansion of equal rights and entitlements. The principles of fostering inclusion and social justice are summarized in the rights-based approach to development, which establishes a link between development policies and international human rights standards. In contrast to charity or a needs-based approach to

Figure 1. The social protection floor



Source: International Labour Organization, Strategy for the extension of social security. Available from http://www.social-protection.org/gimi/gess/ShowTheme.do?tid=2505.

social policy, the rights-based approach includes elements of empowerment that allow people to enlarge their human capital.

Grounded in the human rights principles of equality, participation and access, the rights-based approach requires that basic goods and services such as food, education and health care are available in sufficient quantity, accessible and affordable to everyone without discrimination, and are of a quality that corresponds to the needs of individuals. Obligations of the state relate to establishing the legal foundations, the policy instruments to implement the rights and to measure the outcomes, namely the degree to which the right to food, education or health care is actually enjoyed by all people.

In this regard, states are free to choose and shape appropriate policy instruments. Governments can decide to provide social insurance or to deliver social services directly through their own bureaucracy, but they can also partner with other institutions or organizations. The state is ultimately responsible for the result and accountable to its citizens.

The social protection floor summarizes available options and recommendations in the so-called staircase approach, where basic social protection and health-care services should be available to the entire population, independent of their ability to pay (figure 1). In essence, this basic protection requires significant vertical redistribution, organized by the state, in order to provide people with a fundament to maintain some resilience to shocks and crises. Higher levels of protection can then be reached through mandatory social insurance among the employed or other types of contributory protection schemes.

Chapter II

II. PUBLIC SECTOR PRODUCTION OF WELFARE

Social welfare systems are the result and the reflection of social power relations. They are not technical or neutral solutions to social problems, but they are politically shaped mechanisms of resource allocation that determine who pays for whom and which social groups are included in or excluded from social benefits.

Political change may therefore require the existing welfare mix to change. As new social groups gain political voice and articulate their interests, new distributive coalitions may emerge, inclined to alter the status quo and introduce new principles of resource allocation.

This chapter looks at the pattern of public welfare provision in Arab countries and examines how it allows for social protection and for human capital formation across social groups or classes. It describes the existing public programmes that are designed to help citizens to cope with lifecycle risks or to alleviate poverty and looks at patterns of inclusion or exclusion. It looks at the way public education or health-care systems help people to acquire education and to maintain their physical health independent of their ability to pay for those services.

A. Public sector employment

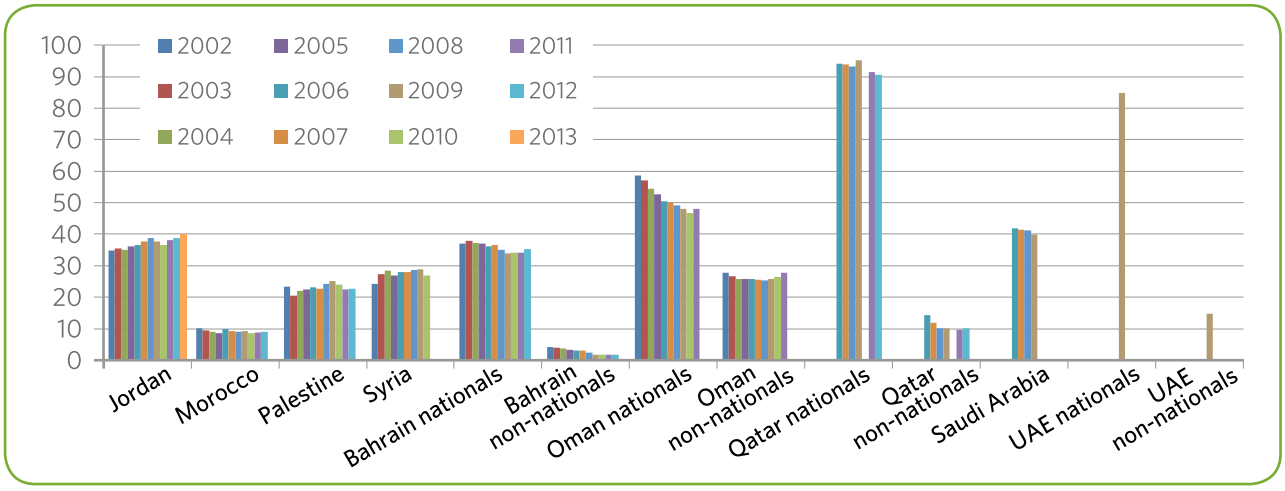
For a long time, public sector employment was regarded as the main source of social welfare throughout the Arab region, and it has often been labelled as an essential part of the social contract. One of the clearest expressions of this policy was the Public Employment Guarantee Scheme in Egypt, introduced in the 1960s, which established a strong sense of entitlement. It was gradually phased out at the end of the 1990s. In the framework of economic and structural adjustment programmes during the 1990s, countries such as Egypt and Jordan vested significant effort into down-sizing public sector employment. Shares of public sector employment are significant, as can be seen in figure 2.

Special programmes in GCC countries strive to increase private sector employment among the national population, but so far results are mixed. The highest share of public employment, at least among the national population, is still found in GCC countries, and the lowest is observed in Morocco and Tunisia.

B. Social protection

Strongly related to the emphasis on public employment is the structure of social protection systems in Arab countries, as the first tier of protection mainly consists of employment-based social insurance programmes. The second tier in several countries is a diverse range of cash transfers and of food, fuel and housing subsidies. The main features of these programmes are similar

Figure 2. Public sector employment as a percentage of total employment, selected ESCWA member countries



Sources: (Left to right) **Jordan**: http://www.dos.gov.jo/owa-user/owa/emp_unemp.p_select?lang=E; **Morocco**: http://www.hcp.ma/Emploi-par-secteur-d-activite-au-niveau-National_a158.html; **Palestine**: Palestinian Central Bureau of Statistics, Labour Force Survey Database, 2000-2012; **Syrian Arab Republic**: Central Bureau of Statistics, 2000 data from statistical abstract, 2001-2009 Labour force survey; **Bahrain**: http://blmi.lmra.bh/2013/03/data/lmr/Table_A99.pdf; **Oman**: http://www.ncsi.gov.om/book/SYB2012/4-governments.pdf; **Qatar**: http://www.qsa.gov.qa/eng/GeneralStatistics.htm; **Saudi Arabia**: Labour force survey data; **United Arab Emirates**: http://www.uaestatistics.gov.ae/ReportPDF/120712_%20Labor%20Force%202009.xls.

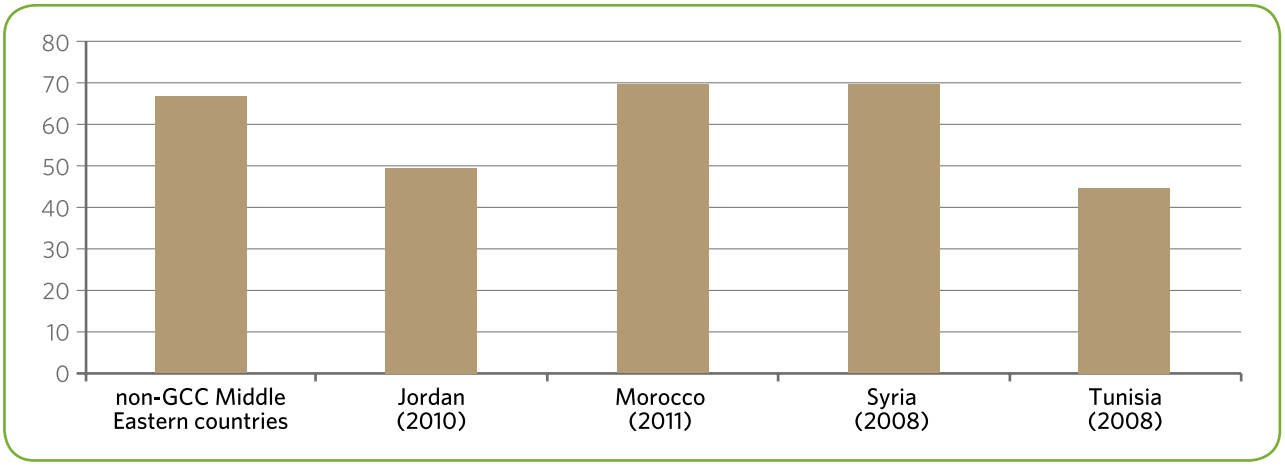
across the region, displaying comparable strengths and weaknesses with regard to the question of access, affordability and quality, as well as with regard to their distributional impact.

1. Social insurance

The social insurance programmes in the region were established beginning in the 1950s in Egypt, the Maghreb and the Mashreq and continuing through the 1970s in most GCC countries. Qatar instituted a social insurance programme in 2002.[1] Employers and employees contribute to social insurance funds, which cover a range of life cycle risks such as old age, disability, sickness or maternity. This kind of insurance is obligatory for all persons with a formal work contract either in the public sector or in the formal private sector. Some countries have established different insurance schemes for different professions, typically for civil servants (Saudi Arabia and the Sudan), members of the armed forces (Jordan, Qatar, Saudi Arabia, the Sudan, Yemen), other public sector employees (Bahrain, Iraq, Kuwait, Lebanon) and employees in the private sector. A system of mutual insurance for citizens of GCC countries has been established. In some countries, voluntary insurance is available for the self-employed (Bahrain, Egypt, Jordan, Saudi Arabia and the Sudan) and for nationals working abroad (Bahrain, Jordan, Qatar, Syrian Arab Republic, Yemen). According to data published in 2010, it was estimated that an average of one third of the workers in selected ESCWA member countries were covered by pension schemes.[2] The biggest legally excluded groups in most countries are agricultural workers, household and family workers, and foreign migrant workers.

De facto exclusion concerns all workers without a formal work contract, namely the entire informal sector. Although exact information is difficult to obtain, current estimates point to high levels of informality (figure 3). On average, in non-GCC Middle Eastern countries, about 67 per

Figure 3. Percentage of labour force not contributing to social security, selected ESCWA member countries



Source: Gatti and others, 2011, p. 6; and http://www.ilo.org/dyn/ilossi/ssimain.home.

cent of the labour force do not contribute to social security and are thus not covered by any pension or health insurance scheme. This concerns mostly agricultural workers, the self-employed in micro- and small enterprises, as well as their employees. In Jordan, around 50 per cent of the labour force did not contribute to a pension scheme in 2010; in Morocco and the Syrian Arab Republic, this share was about 70 per cent (2011; 2008); and in Tunisia about 45 per cent (2008) (figure 3).

Moreover, taking rather low labour-force participation rates into account, which average around 50 per cent (and are especially low among women), leads to the conclusion that the real coverage gap may be even larger. In GCC countries, labour force participation among nationals is in the range of 32.1 to 51.3 per cent of the working age population and the employment rate among nationals is in the range of 20.3 to 48.6 per cent.[3] All employed nationals are covered by relevant schemes, and so the main coverage gap in GCC countries concerns foreign migrant workers, who are mostly excluded.

The main social insurance schemes for public and private sector employees operate as so-called 'pay-as-you-go' (PAYG) systems where current employees pay for the pensions of current retirees. This system allows for inter-temporal and intergenerational redistribution and, in principle, also for vertical redistribution from the richer to the poorer participants. However, in practice, redistribution to poorer people is thought to be limited. Governments contribute as employers, but they may also subsidize the programme if required, as is the case in Iraq and Saudi Arabia. In Egypt, Jordan, Qatar and Saudi Arabia, Governments covers any deficit the programme may incur, and in Qatar the Government fully covers the administrative costs as well.

Health-care insurance is part of social insurance schemes in seven ESCWA member countries, namely Egypt, Jordan, Lebanon, Libya, Morocco, Palestine and Tunisia. These funds reimburse costs for medical treatment in public and sometimes also private clinics (Lebanon). They may also run a parallel network of health-care facilities, which are accessible only for insured members (Egypt and Tunisia).

The risk of unemployment is currently covered in different ways. Until recently, the most common

approach was to oblige the employer to pay high separation indemnities when work contracts were terminated.[4] However, as this approach imposes high costs on the employer and limits mobility within the labour market, Governments are gradually switching towards insurance programmes. Bahrain, Egypt, Jordan and Tunisia are currently operating unemployment insurance systems, which, apart from Jordan, allow for some horizontal redistribution. The Jordanian system is based on individual accounts, which function as a savings scheme and provide individual, inter-temporal equalization.

Across Arab countries, these social insurance systems help people to build up some financial resilience, to mitigate the impact of the most common risks and to enjoy benefits like sick pay, maternity and so on. Other parts of the population, however, who are not (yet) covered by these schemes, are supposed to be assisted through a second tier of social assistance, sometimes also called social safety nets. In most countries these take the form of general price subsidies and targeted social assistance.

2. General subsidies

In addition to social insurance schemes, which cover formal sector employees, almost all Arab States operate programmes that subsidize a range of commodities, including fuel, food and housing. The main objective of these indirect transfers is to reduce poverty by improving access to the subsidized goods or services through price stabilization. The rationale is also rooted in the vulnerability of all Arab countries to food price volatility because of their high import dependence. On average, Arab countries spend 5.7 per cent of GDP on fuel and food subsidies.[5]

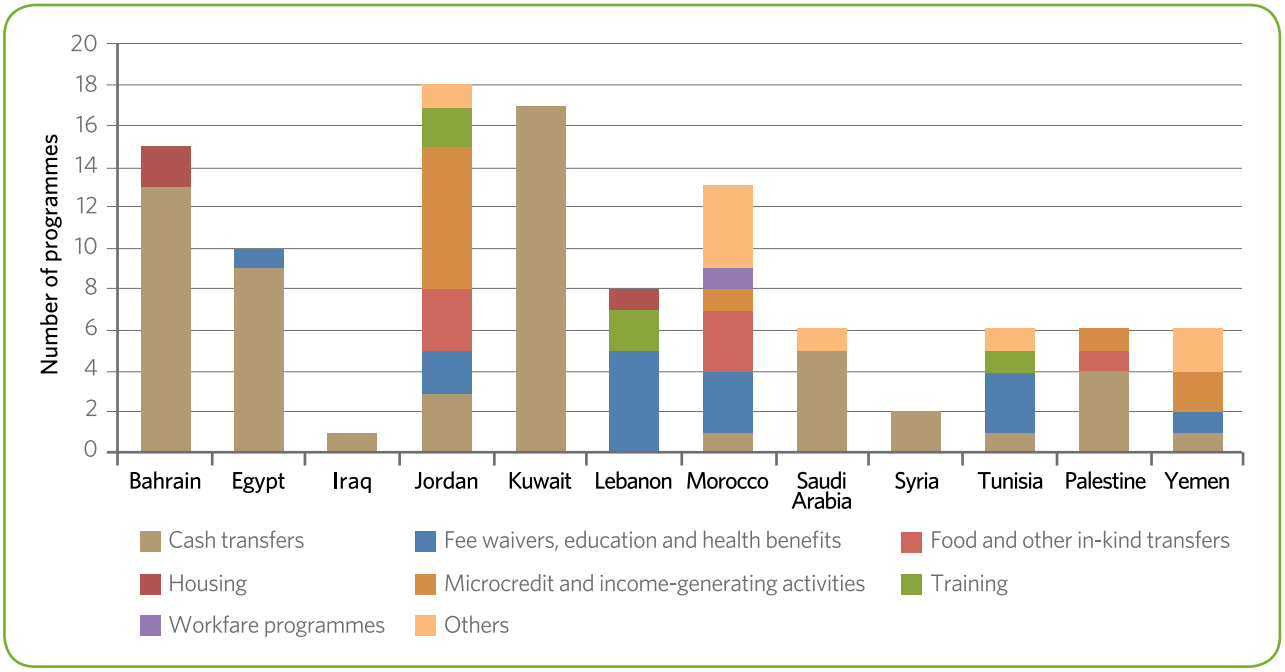
In principle, such subsidies can have direct and broad impact on the situation of the poorest populations. Financed by general government revenues, they may effect some vertical redistribution by transferring resources from the rich to the poor, provided several conditions are met. One condition is to ensure that subsidies go either to the most vulnerable people or to those products that are consumed exclusively (or at least mostly) by the poor. Several Arab countries try to achieve this through issuing ration cards (Egypt and Iraq), through packaging subsidized products in a less convenient way (milk and oil in Tunisia), or through subsiding products of less attractive quality (certain types of bread in Egypt and Tunisia).[6] Vertical redistribution also depends on the main sources of general government revenue. Depending on whether these are obtained mainly from corporate or progressive income taxes or from consumption taxes, the distributional effects may be progressive (the rich fund the poor) or regressive (the poor fund the rich).

On both accounts, the Arab region does not fare very well. Targeting, in general, is not very effective because fuel subsidies, especially in Egypt and Yemen, are captured by the richest quintile of the population, as they consume more energy.[7] Similarly, subsidized apartment buildings tend to be situated in middle-class neighbourhoods of big cities that are too expensive for the urban poor.[8] The structure of public revenue adds to the regressive distributional effects of fuel subsidies, as consumption and sales taxes are one of the main sources of revenue (annex V). By contrast, the distributional effects of food subsidies may be more equal as the poor spend a higher share of their income on food.

3. Social assistance and targeted support programmes

More specific support for people in need is provided through various cash or in-kind transfer programmes, as well as housing support and other benefits (figure 4). Typical programmes are the Social Pension Programme in Egypt, the Social Protection Network in Iraq, the Social Welfare

Figure 4. Social assistance programmes in selected Arab countries



Source: Silva and others, 2013, p. 114.

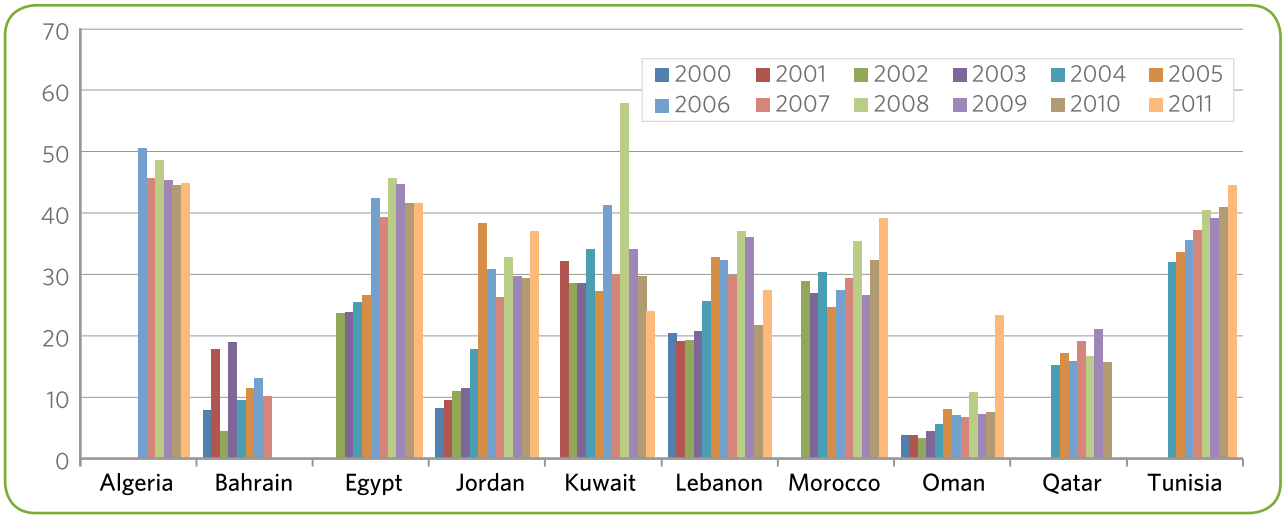
Fund and the Labour Intensive Public Works Programme in Yemen and the National Aid Fund in Jordan. There are education grants and school support programmes in Egypt, Jordan, Lebanon and Morocco, which provide support to poor households.

A common feature of those programmes is their fragmentation into many different funds, and as each programme applies its own selection and targeting system, their administration tends to be heavy, which endangers efficiency. In Egypt, a multiplicity of funds for long-term transfers (the social pension fund) or temporary assistance (a special fund for former government employees, Bank Nasser) leads to overlaps, confusion and leakage of scarce resources because monitoring is difficult.[9] In Morocco, 12 different programmes aim to increase school enrolment, and in Jordan a lack of coordination is observed between the National Aid Fund and assistance disbursed by the Ministry of Social Affairs.[10]

Fragmentation is especially of concern as the overall resources available for social assistance programmes are limited. On average, countries in the region spend 0.74 per cent of GDP on targeted support, ranging from 0.04 per cent in Kuwait to 1.9 per cent in Iraq. Comparatively high absolute expenditures on social assistance are mainly driven by fuel and food subsidies, which constitute 5.7 per cent of GDP. Accordingly, benefits in the targeted programmes are relatively small and insufficient. In Egypt, for example, in 2008/09 social assistance was found to cover 93.8 per cent of the food expenditure, but only 64.6 per cent of the total expenditure of the lowest expenditure bracket.[11] In Iraq they amount to less than 10 per cent of the median income of the lowest consumption quintile and in Jordan, assistance covers 71 per cent of the poverty line.[12]

In addition, poor targeting contributes to the rather weak overall impact of social assistance

Figure 5. Subsidies and other transfers, selected Arab countries
(Percentage of government expenditure)



Source: World Bank, WDI database.

programmes on poverty. Most programmes target certain categories of the population such as orphans, elderly people and widows. This means that some vulnerable households may not be covered, for example those with a male head of household that belongs to the working poor, whereas some people who belong to targeted categories may actually not be poor. Errors of inclusion seem to be especially large for individual programmes like the Social Protection Net in Iraq, where about two thirds of beneficiaries live above the poverty line.[13] In Egypt, in 2004, 18 per cent of the population over 65 years of age was covered by the social pension programme, but only 8 per cent of the poorest quintile was reached.[14] Even the food ration card system in Egypt fails to cover about 20 per cent of the bottom quintile of the income distribution.[15] In Jordan, the National Assistance Fund reaches 16.5 per cent of the bottom quintile. In the region, it is estimated that 70 per cent of the poorest households receive no income support transfers.[16] As household surveys may underestimate the number of poor people, especially in urban slum areas, actual coverage may even be lower.

Overall, subsidies and targeted social assistance programmes constitute a considerable share of GDP (see figure 5 and annex VI), but they may not be sufficiently effective as a second tier of social protection to prevent people from falling into poverty.

Subsidies do have considerable impact on poverty. Food subsidies in Egypt and Iraq are seen to reduce poverty by 30 per cent, and food, gas and water subsidies in Jordan reduced poverty by 15 per cent. However, undernourishment and stunting among children under 5 years of age is still of concern.[17] Thus the impact of food subsidies appears limited even though a large share of government expenditure goes into them, indicating that they are not the most effective safety net. However, food subsidies are difficult to change because they are popular among large parts of the population with political voice.

Insufficient funding, high fragmentation and inaccurate targeting of assistance limit the efficiency and effectiveness of social assistance programmes. Some of the programmes are regressive in the sense that they provide assistance

not only to those in need but also to wealthier populations. Further, except for support that is provided to rural areas, categorical targeting is mainly geared towards people experiencing life cycle risks. Targeted support usually does not sufficiently cover economic risks like unemployment or other forms of income poverty. Complex and lengthy administrative procedures prevent systems from flexibly responding to the needs of populations whose income is highly variable. In the period between 2005 and 2008 in Egypt, 55 per cent of the population experienced poverty or near poverty.[18]

Recent studies have concluded that the impact of social assistance programmes on poverty and inequality has been rather limited. In Egypt, Iraq and Yemen, those programmes were found to reduce poverty by less than 5 per cent. In Jordan the impact was almost 10 per cent, and in Palestine about 18 per cent. In Egypt, the limited effects of social security programmes may also be illustrated by the fact that during a period of strong economic growth (between 2000 and 2005) poverty grew significantly, and to a larger extent in rural than in urban areas.[19]

The effects on inequality are similar: assistance in Palestine reduced the Gini coefficient by almost 7 per cent, but the effects in Egypt, Yemen and Iraq were much smaller and the Gini declined by less than 1 per cent.

C. Public social services

Unlike social protection systems, which are meant to assist people in managing economic and life cycle risks, social services ensure long-term human capital formation. Equitable access to education and health care are among the most important tools for people to find their way out of poverty, improve social mobility and increase their quality of life. Conversely, inequitable access to those services tends to deepen poverty and inequality, and negatively influences social cohesion and economic growth. Such positive or negative externalities are the reason for strong public sector involvement in social services, either directly through public provision or indirectly through strong regulation.

Most Arab countries have made visible gains towards the Millennium Development Goals (MDGs). Life expectancy increased significantly over the past 30 years. Maternal health improved and child mortality rates decreased, although progress in the least developed countries (LDCs) in the Arab region is too slow and the targets will not be met by 2015.[20] School enrolment also increased, the gender gap is closing, and school completion rates have improved. Across the Arab region, 83 per cent of children who enrol in grade 1 will complete their primary education. Literacy rates increased significantly, with GCC countries nearly achieving 100 per cent, and LDCs reaching 85 per cent.[21] However, large in-country disparities remain, pointing to highly inequitable access to social services across geographical regions and income groups.

1. Health care

All Arab countries have established public health-care systems designed to span all geographic regions and to guarantee equitable access to all social groups. Financed by general government revenues, health-care services are meant to be provided either for a nominal fee or completely free of charge. The ministries of health are usually responsible for managing health-care services provided by the public sector, as well as for the regulation of services offered by private health-care providers, practitioners or clinics. In most countries, public health services are provided through a network of public hospitals, clinics and health centres, with the exception of the Lebanese health-care system, which is dominated by private providers.

Table 1. Indicators of health inequality, selected ESCWA member countries, latest available year

	Antenatal care coverage: at least 4 visits				Births attended by skilled health personnel				DTP3 immunization of 1 year-olds			
	Place of residence		Wealth quintile		Place of residence		Wealth quintile		Place of residence		Wealth quintile	
	Rural	Urban	Lowest	Highest	Rural	Urban	Lowest	Highest	Rural	Urban	Lowest	Highest
Egypt	58	80	42	89	72	90	55	97	97	99	97	99
Iraq	..	..	..	..	78	95	..	..	49	67	..	..
Jordan	91	95	90	98	99	99	98	100	97	97.5	97	98
Morocco	15	44	11	60	55[a]	92[a]	30[a]	95[a]	92	97	89	98
Syria	59[b]	68[b]	..	..	88	98	78	99	74	76	62	80
Tunisia	55	75	..	..	89	98	..	..	..	..	..	..
Yemen	8[c]	33[c]	..	..	26	62	17	74	47	69	35	86

	Children under 5 who are stunted				Under 5 mortality *(Per 1,000 births)*			
	Place of residence		Wealth quintile		Place of residence		Wealth quintile	
	Rural	Urban	Lowest	Highest	Rural	Urban	Lowest	Highest
Egypt	30	27	30	27	36	29	48	19
Iraq	31	25	..	..	..	..	..	..
Jordan	..	..	13[d]	1.5[d]	..	..	38[d]	38[d]
Morocco	17	14	18	9	27	21	30	27
Syria	29	28	36	26	..	..	22[e]	23[e]
Tunisia	..	..	..	..	..	..	..	..
Yemen	..	..	..	..	..	..	118[e]	37[e]

Abbreviation: DTP3, Diphtheria, pertussis and tetanus (DTP3 indicates complete coverage with the DTP vaccine's three doses).
Notes: Two dots (..) indicate that data are not available. Figures are percentages except as noted.
a/www.childinfo.org, 2011.
b/http://www.childinfo.org/antenatal_care_four.php, 2009-2010.
c/http://www.childinfo.org/antenatal_care_four.php, 2004.
d/Jordan Health Equity and Financial Protection Data Sheet, World Bank, 2009.
e/ESCWA and the League of Arab States, 2013, p. 27.
Sources: **Egypt**: Demographic and Health Survey 2008; **Iraq**: MICS 2006; **Jordan**: Demographic and Health Survey 2007; **Morocco**: Global Health Observatory Data Repository, 2003-2004; **Syrian Arab Republic**: MICS 2006; **Tunisia**: MICS 2006; **Yemen**: MICS 2006; www.childinfo.org, 2006-2007.

In addition to those universal public services, several countries have developed social health insurance systems, mainly for employees of the public sector and the formal private sector. In Egypt, Jordan and Tunisia, such insurance systems operate health-care facilities for their members. In Egypt, the Health Insurance Organization, the primary insurance provider, covered around 57 per cent of the population in 2008/2009. Coverage rates were higher in Tunisia (99 per cent) and Jordan (83 per cent).[22] In Lebanon the Ministry of Public Health serves as the insurer of last resort for 53 per cent of the population, those who are not covered by employment-based or private health insurance.[23] Unequal coverage across social groups mostly stems from differences in their employment status: men are more often covered than women and the wealthier more often than the poor. In Egypt the typical insured person is an urban male.[24] The structure of health service delivery in Jordan in 2000 disadvantaged the uninsured,

Table 2. Health expenditures in selected Arab countries, world regions and Turkey, 2011

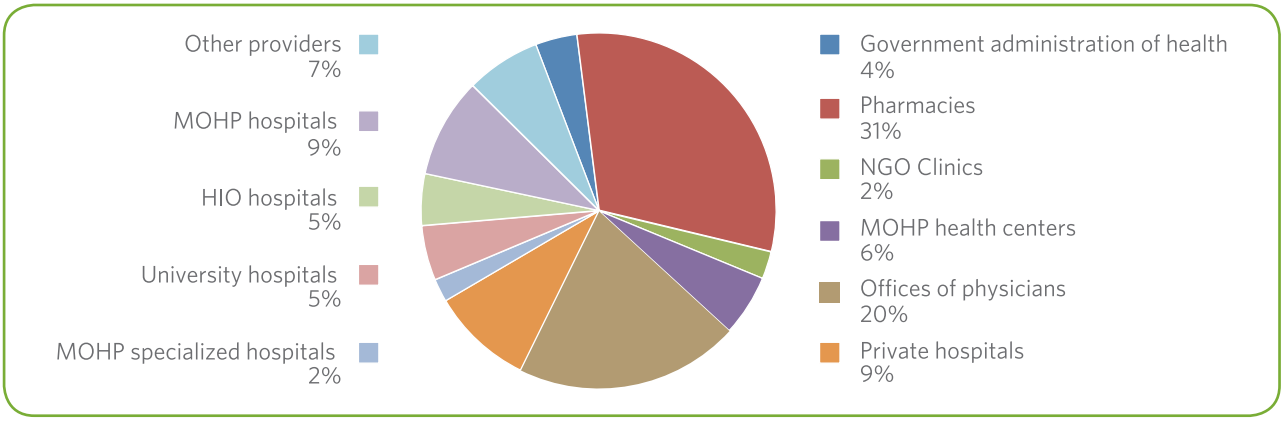
Country	Total	Public	Private	Public	Out-of-pocket	Out-of-pocket
	Percentage of GDP			Percentage of total		Percentage of private
Bahrain	3.8	2.7	1.1	71.0	16.6	57.2
Egypt	4.9	2.0	2.9	40.5	58.2	97.7
Iraq	8.3	6.7	1.6	80.7	19.3	100.0
Jordan	8.4	5.7	2.7	67.7	24.7	76.5
Kuwait	2.7	2.2	0.5	82.2	16.1	90.6
Lebanon	6.3	1.6	4.7	25.5	56.5	75.8
Libya	4.4	3.0	1.4	68.8	31.2	100.0
Morocco	6.0	2.1	4.0	34.3	58.0	88.3
Oman	2.3	1.9	0.4	80.8	11.4	59.7
Qatar	1.9	1.5	0.4	78.6	13.6	63.8
Saudi Arabia	3.7	2.5	1.1	68.9	18.0	58.1
Sudan	8.4	2.4	6.0	28.4	69.1	96.5
Syrian Arab Republic	3.7	1.8	1.9	49.0	51.0	100.0
Tunisia	6.2	3.4	2.8	55.1	39.5	87.9
United Arab Emirates	3.3	2.5	0.9	74.4	16.2	63.2
West Bank and Gaza	..	..	..	..	..	..
Yemen	5.5	1.1	4.3	20.9	78.1	98.7
East Asia and the Pacific	6.8	4.6	2.2	67.6	25.3	72.9
Europe and Central Asia	9.6	7.2	2.4	75.4	16.1	74.8
Euro area	10.6	8.1	2.5	76.0	14.1	67.3
Latin America and the Caribbean	7.6	3.8	3.8	50.3	33.9	74.4
Middle East and North Africa	4.4	2.8	1.6	59.3	33.7	73.2
South Asia	3.8	1.2	2.6	31.2	59.7	88.6
Sub-Saharan Africa	6.5	2.9	3.6	45.1	29.8	67.0
Turkey	6.7	5.0	1.7	74.9	16.1	64.4

Source: World Bank, WDI database.
Note: Two dots (..) indicate that data are not available.

who were likely among the poorest quintiles of the population.[25]

Despite the apparently comprehensive provision of health care, significant disparities in health outcomes indicate major inequalities in access to health services and considerable gaps. Table 1 gives an overview of some indicators of health inequality in selected ESCWA member countries. Wide geographical disparities in health status indicators between rural and urban areas are observed in Yemen, and the under 5 mortality rate among the poorest quintile is three times the rate among the richest. Regional disparities are stark as well in Tunisia, where the coastal regions are relatively well served, but other governorates suffer from a lack of general practitioners.[26] The recent *Household Health Expenditure and Utilization Survey* in Egypt revealed that existing institutions and programmes are not able to provide equitable care across economic classes.[27] In 2008, deficits in three out of seven child health

Figure 6. Providers as share of total health expenditure in Egypt, 2009



Abbreviations: HIO, Health Insurance Organization; MOHP, Ministry of Health and Polulation.
Source: Nakhimovsky and others, 2011, p. 22.

indicators were significantly concentrated among the Egyptian poor. In Morocco in 2003/04, the concentration among the poor was significantly higher in four of these indicators.[28] Financial or physical accessibility problems resulted in the finding that unmet demand for health in Morocco was about 2.5 times higher among the poorest patients (54.9 per cent) than among the richest (23.1 per cent).[29]

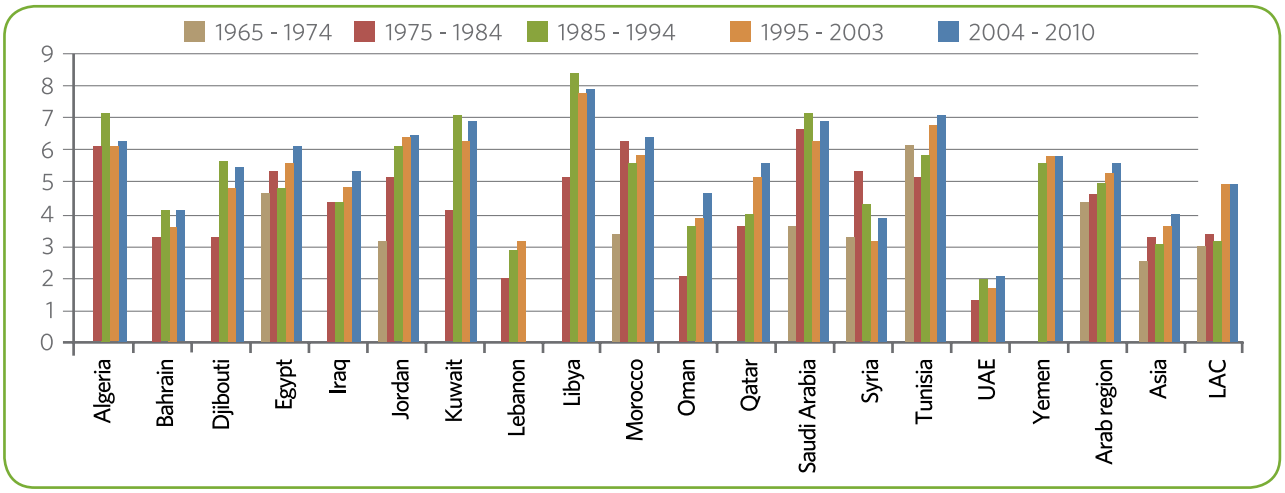
Unequal access to health care is often related to insufficient and inequitable financing, and especially to high out-of-pocket expenditure. In the region on average, about one third of total health expenditure is paid out of pocket – a share similar to that registered in Latin America, higher than in almost all other world regions except South Asia. In individual countries, especially in LDCs like Yemen and the Sudan, out-of-pocket-payments reach 78 per cent and 69 per cent of total health expenditure respectively, but also in Egypt, Morocco, Lebanon and the Syrian Arab Republic, the share lies well above 50 per cent (table 2).

It is mostly the poorer parts of the population who are not covered by health insurance schemes, and at the same time, they are exposed to more hazardous working and living conditions, and so out-of-pocket payments are especially burdensome for them. The double effect of economic hardship and ill health can push households into a downward spiral of ever deeper poverty and exclusion. In the region, the share of households which incur so-called 'catastrophic payments' ranges between 7 and 13 per cent of the population, with the highest share in Lebanon.[30]

Typically, high private expenditure goes hand in hand with low public funding for health care. As table 2 shows, in 2011 public expenditures ranged between 1.1 per cent of GDP (Yemen) and 3 per cent of GDP (Libya), with only Tunisia (3.4 per cent), Jordan (5.7 per cent) and Iraq (6.7 per cent) spending a higher share of public resources. By comparison, during the same year, Turkey spent about 5 per cent of GDP on public health care. Comparing regional averages shows that the average health expenditure of the Middle East and North Africa (2.8 per cent of GDP) is below that of all other world regions except South Asia.

As discussed earlier with regard to the social security systems, underfunding and fragmentation are structural impediments to better effectiveness of public health-care systems. In Yemen, the Ministry of Health does not sufficiently control funds that are flowing through multiple channels.[31]

Figure 7. Public expenditure on education, selected Arab countries and world regions, 1965-2010
(Percentage of GDP)



Source: ESCWA and the League of Arab States, 2013, p. 21, based on World Bank and UNESCO data.

In Lebanon six public funding agencies affiliated with five government bodies result in significant duplication of financing and management.[32] Public and private entities within the health-care system in Qatar have completely separate financing structures, which may indicate duplications and inefficiencies.[33] In Egypt an ongoing reform programme is currently integrating several programmes to deal with high fragmentation of the public health sector.[34] Figure 6 illustrates the level of fragmentation in the Egyptian health-care system across different providers.

2. Education

Education for all was one of the most important priorities of the Arab region after independence, and many countries including Algeria, Egypt, Jordan, Lebanon Morocco, the Syrian Arab Republic and Yemen established access to free education as a constitutional right.[35] The public education systems, controlled by the Ministry of education, were designed to cater to the entire population in all geographic areas; schools were built, textbooks created, teachers trained until physical access was guaranteed to a certain extent. In addition, Egypt, Morocco and Yemen maintained the traditional network of Islamic schools in parallel to the modern school system (see chapter IV). Figure 7 shows public expenditure on education as a share of GDP from 1965 to 2010.

The average level of public expenditures on education in Middle Eastern countries had consistently been above that of other developing regions since 1965. The effect of high political attention and high investment has resulted in remarkable achievements. The proportion of the adult population with no formal education, which was more than 80 per cent in Algeria, Egypt, Iraq and Tunisia in the 1970s, declined by about 50 per cent by 2000.[36] Across the region, significant progress was also made towards gender parity in education.

However, success is still unequal across income groups and sex. Currently, about 20 per cent of the poorest children in Egypt do not enter primary school, and in Algeria, Iraq, Oman, the Syrian Arab Republic and Yemen, more than two thirds of out-of-school children are girls.[37] Among the

poorest Egyptians between 20 and 24 years of age, 37 per cent of the poorest have less than two years of education and 40 per cent attended school for less than four years. Among youth of the same age group in Yemen, 60 per cent of the poorest have less than two years of education and 65 per cent less than four years. In Morocco, 73 per cent went to school less than two years, and 80 per cent less than four years.[38] In Yemen, where education from the secondary level onwards is separate for boys and girls, more schools are available for boys than for girls.[39]

Rural/urban disparities are still strong, and in some countries enrolment rates among the poor in rural areas are significantly lower than among the non-poor. In the year 2000, enrolment among the rural poor in Tunisia was at 67 per cent, as compared to 82 per cent among the urban non-poor. In Yemen in 1998, enrolment of the rural poor was nearly 60 per cent, as compared to 92 per cent among the urban non-poor.[40] In 2004 the illiteracy rate in Tunisia was 30 per cent in rural areas and 15 per cent in urban areas.[41] Some rural areas in Egypt, Morocco and Yemen record higher proportions of people with very little schooling.[42]

Education quality is of concern because it is strongly linked with a number of different development outcomes. Not only is better education the main tool for individuals to achieve social mobility and to qualify for better jobs, it is also essential for countries to achieve higher productivity and economic growth. Moreover, better education also leads to higher civic participation and is strongly related to better social chances of children. Unfortunately, deteriorating quality of primary as well as secondary education is observed in some countries, namely Egypt, Morocco and Yemen.[43] International learning achievement tests, such as the Trends in International Mathematics and Science Study (TIMSS) and Programme for International Student Assessment (PISA), show that Arab countries lie below the international average, and of special concern is the fact that education outcomes are strongly related to household socioeconomic status.[44]

To a certain extent, such disparities are typical signs of a development process, but they are also the result of policy decisions that have favoured certain social groups. Many Arab countries have decided to invest more strongly in secondary education than in primary education, and to support university level education[45] - a decision that tends to disadvantage lower income groups that are less able to support children pursuing secondary or tertiary education. Similarly, decisions about the mix of service providers seem to have a strong impact on the learning results of different social groups. Comprehensive public provision of good quality education at the primary level is better able to guarantee equitable access for all population groups and to give every child the chance to develop her or his talents, whereas free public education at higher education levels tends to favour the wealthier parts. However, over the period from 1980 to 2003, enrolment in private schools at the primary level was high and/or increasing in Bahrain, Jordan, Kuwait, Lebanon, Morocco, Qatar, Saudi Arabia and the United Arab Emirates (see chapter III).[46]

Similarly, in Tunisia and Saudi Arabia learning inequalities have increased, which may be related to a greater involvement of private tutors and private schools in education.[47] In Lebanon, the country with the highest enrolment in private education at all levels, only 5 per cent of poor students attend private schools as opposed to 66 per cent of students from wealthier households. In fact, out of 1,000 students who enrol in private school at the first grade, 225 reach the baccalaureate without repeating a year, but out of 1000 students who enter the public school system, only 9 will reach the baccalaureate without repeating a year.[48]

D. Summary: structural problems and political change

In principle, the strength of the state lies in its ability to provide social protection and services to all, independent of their ability to pay. Harnessing that strength would allow governments to organize social policy in a way that facilitates equal access to protection and good quality education or health-care services for all income groups across rural and urban areas. Given the overarching commitment to human rights and to poverty reduction, but also the importance of public health and a well-educated population for the process of national development, governments must actively care for vulnerable populations.

However, it is precisely this capacity of the state to equalize opportunities across income groups, which is not developed in Arab countries, except for GCC countries. Social services and support systems mainly cater to the urban middle class, and are unable to reach everybody, especially the poor and destitute. The inequities and gaps built into the current welfare systems are evident in the fact that around two thirds of the labour force are not covered by pension schemes, and that 70 per cent of the lowest income quintile remain without income support transfers. Furthermore, education outcomes and health-care indicators point to the structural disadvantage of rural and poorer populations.

Established under a social contract that was grounded in a promise of effective redistribution and of development progress, the systems were increasingly less able to integrate the growing population and to reach the newly emerging middle class. Education systems were no longer able to fulfil their redistributional role, and high private spending on education and health-care services defied the notion of education and health care as public goods. Neither the public nor the private sectors were able to integrate the growing workforce into decent employment.

When excluded groups raised their voices, demanding their political and social citizenship rights, Arab governments were quick to react (table 3). Between January and September 2011, all Governments raised the salaries of public sector employees (either across the board or for specific groups), and at least seven countries increased public sector employment. Subsidies were increased or taxes on fuel were reduced in all countries except Qatar and Yemen, thus reversing previous reform decisions. Bahrain, Kuwait, Oman and Saudi Arabia established additional cash transfers to students or job seekers. GCC countries increased health-care spending and investment to improve the quality and availability of services, and almost all countries introduced special programmes for either disadvantaged areas or for specific social needs such as housing.

However, given the way welfare systems are currently set up, they were not able to yield greater social integration. Only a few of these interventions reached people in poverty or those threatened by social decline. By directing even more resources to relatively well-situated public sector employees or to insufficiently targeted subsidies and transfer programmes, Governments may have widened the existing social gaps instead of alleviating them.

Today, inefficient public welfare provision creates two types of gaps. Quality gaps result from insufficient quality of public services, which do not meet the expectations of citizens and do not support the formation of human capital. Quantity gaps result from insufficient coverage of the population and especially insufficient outreach of public services to rural areas and to poorer populations.

From a rights-based perspective, this means that increasing welfare dualism undermined the availability, accessibility and quality of social protection and social services for large parts of the

Table 3. Social interventions of selected Arab countries, 2010-2012

Country	Algeria	Bahrain	Egypt	Iraq	Jordan	Kuwait	Lebanon	Libya	Morocco	Oman	Qatar	Saudi Arabia	Syrian Arab Republic	Tunisia	United Arab Emirates	Yemen
Public sector salaries	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Public sector employment					X					X		X	X	X	X	X
Public pensions		X		X						X					X	
Subsidies and in-kind transfers	X	X	X	X	X	X	X	X	X	X		X	X	X	X	
Social transfers	X					X		X		X		X	X	X		X
Health and education		X			X					X		X	X			X
Other initiatives	X	X	X	X	X		X		X	X	X	X	X	X	X	X

Sources: See annex VII.

population. The social protection floor of public services and transfers became porous and was not able to serve as a fundament on which people could rely in times of need.

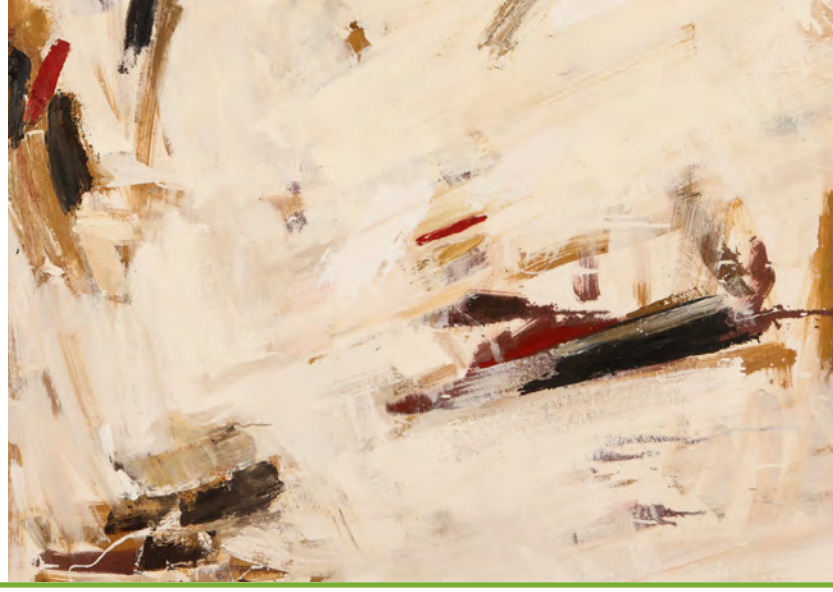
Available resources are limited for most Governments in the region, thus they must seek out creative ways to expand their policy infrastructure in order to reach beyond existing networks to serve marginalized areas or social groups. They must search for partners who can share the responsibilities and with whom they can develop synergies in closing the social gaps.

The following two chapters lay out how the private sector and civil society organizations are involved in social protection and the provision of social services and discuss their capacities and limitations to fill the quantity and quality gaps left behind by the public sector.

Chapter III

III. THE PRIVATE SECTOR

Commercial Provision of Social Services and Corporate Philantropy



The private sector looks for business opportunities and market niches with the objective of making profit or at least achieving cost coverage. In countries with large gaps in the existing provision of social services such as health and education, the private sector will identify those gaps as market niches. Because health and education services fulfil essential human needs, individuals are often willing to shoulder high prices to have access to quality services.

Social services, especially education and health, are of strategic interest to countries, which is one reason why the public sector often strives to provide and regulate these services. In addition, according to the International Covenant on Economic and Social Rights, they are considered as essential human rights, which the state is obliged to guarantee. Thus, the following questions arise: what role can the private sector have in a welfare mix? Can the private sector be a provider of services that are essential human rights and that the state is obliged to guarantee? How can the state guarantee human rights with equity of access, if the private sector is the provider of social services?

The private sector can be involved in the provision of social services through two mechanisms: either by providing social services as a core (profit-generating) activity or providing social services as an expression of corporate social responsibility.

This chapter will discuss the kind of social services typically provided by the private sector in ESCWA member countries. It describes the ways the state and the private sector cooperate in the provision of those services and discusses the main opportunities and risks in the provision of social services by the private sector in the framework of a rights-based approach, especially with regards to coverage, equity of access and sustainability.

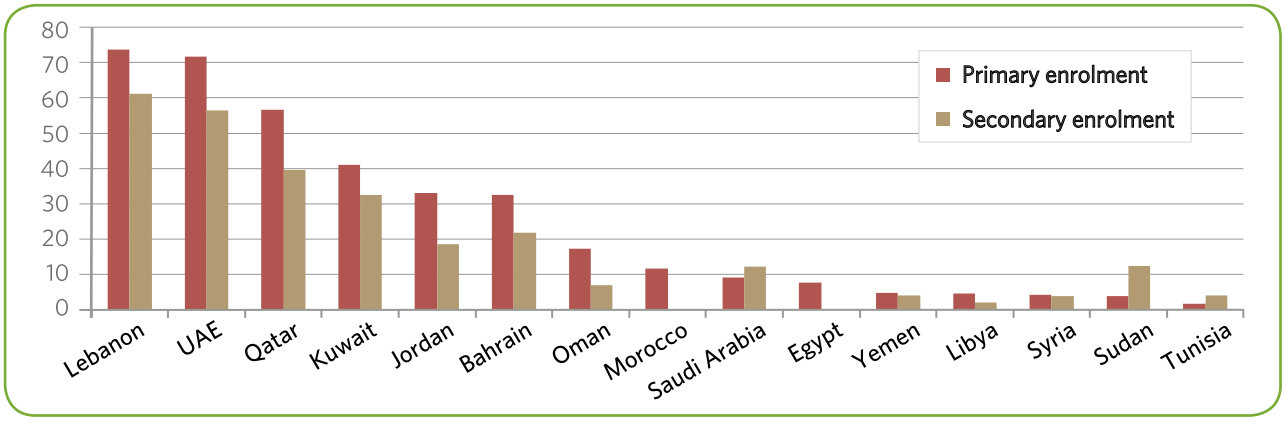
It must be noted that the delineation of private sector and civil society activities are often blurred, especially in the provision of social services. Civil society organizations sometimes form either for-profit or non-profit organizations for the delivery of social services and will be discussed in chapter IV.

A. How the private sector contributes to the provision of social services in ESCWA member countries

1. Role of the private sector in the provision of social services: overview

Several ESCWA member countries have established a constitutional right to education and health and have set up public systems of service provision. However, some countries are facing challenges in fulfilling these commitments, which often are characterized by limited coverage or limited quality of public services. Population

Figure 8. Private enrolment as a percentage of total enrolment in primary and secondary schools, selected ESCWA member countries



Notes: Data for **Iraq** and **Palestine** are not available. Data are for 2011 except as follows: **Jordan**, **Saudi Arabia**, **Syrian Arab Republic** and **United Arab Emirates**, 2010; **Sudan**, 2009; **Egypt**, 2007, **Libya**, 2006.
Source: UNESCO Institute of Statistics, available from WDI database.

growth, conflict and economic hardships are further straining systems of public service provision, and have deepened and widened the gaps. Those conditions have created room for other actors, namely the private sector.

The levels and ways in which the private sector contributes to the welfare mix in the region vary by sector and by country according to its policies and economic situation. However, there is a general trend towards increasing private provision of social services. In some cases, particularly in GCC countries, private participation is the result of policy design where Governments encourage private sector provision. In other cases, for example in Egypt or Lebanon, the private sector stepped in to meet demands for better quality services that the public sector had not met.

(a) Education

The welfare mix in the education sector in countries of the region ranges from very limited private provision to predominantly private provision and financing of education (figure 8). The latter is the case in Lebanon, Qatar and the United Arab Emirates. In Lebanon, 73 per cent of primary students and 61 per cent of secondary students were enrolled in private schools. Private education, especially at the primary level, also plays an important role in Kuwait with 41 per cent, Jordan with 33.1 per cent and Bahrain with 32.5 per cent. At the other end of the scale, private education plays a small role in Libya, the Syrian Arab Republic and Tunisia, where private primary and secondary enrolments are below 5 per cent. In Libya and the Syrian Arab Republic, education used to be administered by the Government, allowing only a limited number of private schools. In the Sudan, private education plays a small role at the primary level, but is higher at the secondary level with 12.3 per cent.

When analysing the data, it has to be noted that according to the definition of the United Nations Educational, Scientific and Cultural Organization (UNESCO), private schools are institutions that are not operated by a public authority, but controlled and managed by a private agency, such as a religious body, special interest group, foundation, business enterprise or NGO. Thus, it is difficult to determine how many of these private enrolments are in a private school run by a for-profit private company, a non-profit

organization with commercial goals or a civil society organization relying on donations.

In other regions of the world, private enrolment is usually higher at the secondary level than at the primary level (see table 4), which reflects endeavours by many countries to ensure basic education for their people. Several ESCWA member countries diverge from that global trend, and private education at the primary level by far exceeds private education at the secondary level. This is particularly the case in Jordan, Lebanon, Qatar and the United Arab Emirates. In Lebanon, high private primary enrolment may be attributed to the availability of government-subsidized private education for low-income families,[1] which is more prevalent at the primary than at the secondary level. In Dubai, this trend is attributed to the departure of migrant families as their children get older.[2]

While private education has long played a significant role in the welfare mix in Lebanon, it is only beginning to gather momentum in other countries. In GCC and North African countries, the mix between public and private providers has undergone significant changes in the past decade. For example, in Morocco from 2000 to 2011, enrolment in private primary schools increased from 4.7 to 11.8 per cent.[3] Particularly in GCC countries, the increase is largely due to the rising migrant population, but private schools are also becoming increasingly popular among nationals.

The profile of private schools also varies across countries. In the United Arab Emirates, private education can be for-profit or non-profit. For-profit schools are usually managed by a private company, while non-profit schools are typically managed by an interest group, such as a board consisting of parents, a religious group or other civil society organizations. School finances can be provided either by tuition fees, by an external public or private partner or by a combination of the two.

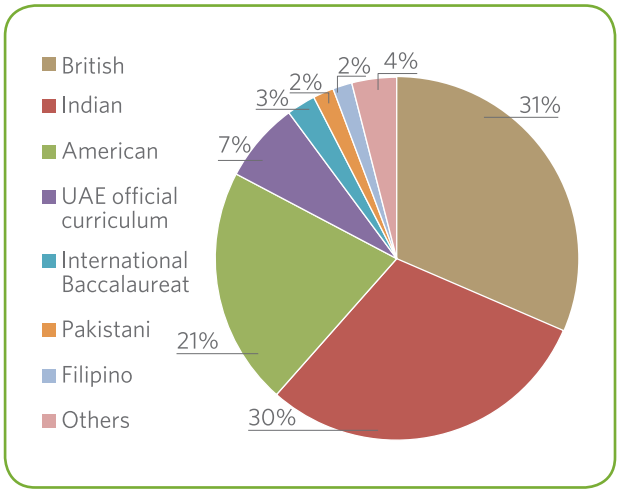
Table 4. Private school enrolment in selected regions, 2011 *(Percentage of total enrolment)*

Region	Primary	Secondary
Arab	7.76	7.44
East Asia and the Pacific	7.44	15.7
Europe and Central Asia	8.18	11.02
Latin American and Caribbean	16.8	18.98
North America	8.59	8.24
Sub-Saharan Africa	16.57	18.26
South Asia	20.4	45.07

Source: UNESCO Institute of Statistics, available from WDI database.

In Dubai, the for-profit sector dominates the educational landscape. In 2012/13, there were 153 private schools including the pre-school level, and 121 of those schools operated on a for-profit basis, covering 83 per cent of private school students. The largest businesses in for-profit private education are GEMS Education with 19 schools, followed by Taaleem with 7 schools and Innoventures with 4 schools. The non-profit Indian High School group that operates according to commercial principles, covers 4.9 per cent of students enrolled in private schools in Dubai.[4] The United Arab Emirates allows private schools to use foreign curricula, targeting the needs of the expatriate workforce. Figure 9 shows that the majority of students are enrolled in schools using a British curriculum, followed by those that use an Indian curriculum. There are also 13 private schools, which mainly cater to children of Arabic-speaking expatriates as well as to Emiratis, that use the curriculum of the Ministry of Education of the United Arab Emirates.[5] In 2012/13, 56.6 per cent of Emirati

Figure 9. Distribution of students enrolled in private schools in Dubai in 2011/12 by curriculum type



Source: Knowledge and Human Development Authority, 2013, p. 7.

students attended private schools and amounted to 13.4 per cent of students enrolled in Dubai's private schools. Emiratis seem to prefer private schools for boys and public schools for girls, as 57 per cent of Emirati students in private schools are boys.[6]

In Lebanon, for-profit schools are the exception. About 41 per cent of private schools are maintained by various religious sects.[7] Other civil society organizations also play a large role in the provision of education. There are, however, a number of schools that are non-profit organizations but operate with commercial principles and achieve full cost recovery.

(b) Health

Private sector involvement in the provision of health care in the Arab region is difficult to measure, however, it seems to have steadily increased since the 1980s.

Lebanon may count as a special case, where the private sector actually leads in health-care provision. In 2008, 92 of the 149 hospitals in the country were private and for-profit. There were only 5 public hospitals and the rest were run by various civil society organizations (discussed further in chapter IV).[8] Even before that time, it was reported that a large number of doctors and dentists were treating private outpatients on a fee-for-service basis. Dentists were concentrated mainly in the highly urbanized areas of Beirut and Mount Lebanon.[9]

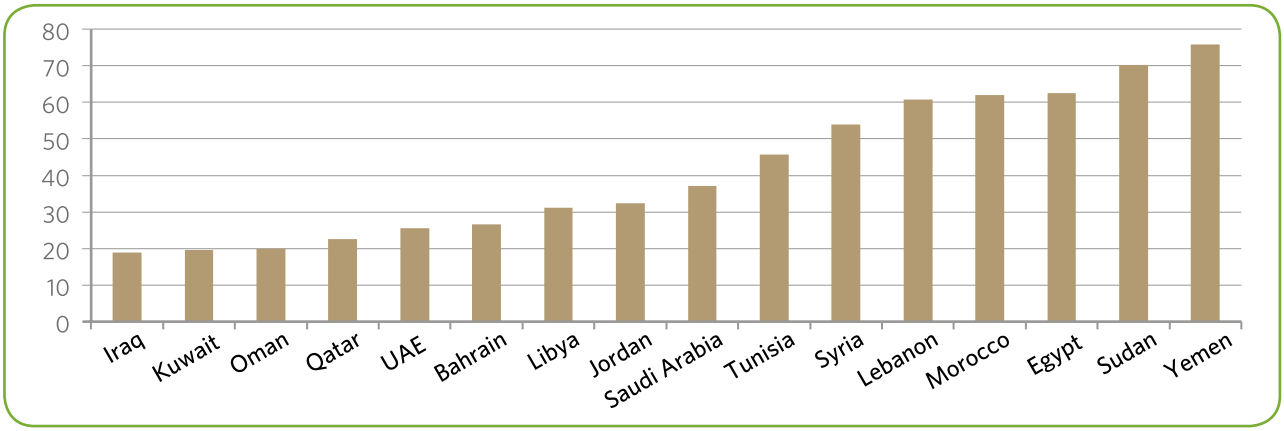
In other countries of the region, particularly in Egypt, the reduction in government spending for social services, which took place in the 1980s during a period of liberalization and deregulation, led to the emergence of private health-care service providers. Individuals switched to private service providers because the quality of services was perceived to be higher than that of public sector services, specifically in terms of shorter waiting times and better treatment by doctors.[10] In urban areas of the Sudan, the private sector has increased steadily since the 1990s as public spending on health fell. In 2005, all full-time clinics in Khartoum were private, as well as 58.3 per cent of hospitals. The private sector did not operate any facilities in rural areas.[11]

Tunisia has been encouraging the private sector to provide health-care services since the 1990s, and by 2010, 34 per cent of health care was privately provided. Among private facilities 84 per cent provided outpatient services and the remainder provided inpatient services.[12]

In the Syrian Arab Republic, the health sector was opened to private providers in 2005. Since then, private providers have increased their presence by 41 per cent. The emerging Syrian middle class preferred to use private services.[13]

All over the Arab region, the private sector tends to be most active in outpatient care, pharmacies and specialty care, such as dentistry. According to the World Health Organization, in Tunisia in

Figure 10. Private health expenditure as a percentage of total health expenditure in ESCWA member countries



Note: Data are for 2010. Data for Palestine are not available.
Source: World Bank, WDI database.

2004, the private sector employed 83 per cent of pharmacists and 72 per cent of dentists; in Jordan it employed 61 per cent of physicians, 93 per cent of pharmacists and 71 per cent of dentists.[14]

There are also large private for-profit hospitals, operating without government involvement. In Egypt, Jordan, Lebanon and the United Arab Emirates, a modern for-profit private sector, providing inpatient services on a fee-for-service basis has evolved in order to meet the demands of the wealthy. Some of these hospitals are internationally accredited and target medical tourists. In addition to large specialty clinics, there are also small private hospitals, mainly in Egypt and Lebanon, that provide inpatient care.

Some countries took policy decisions to shift the welfare mix and increase the private provision of health care. This is the case in GCC countries, which had initially offered public health-care services free of charge for all residents, including non-nationals. In Saudi Arabia, even temporary visitors, such as pilgrims, were covered. The public sector controlled all stages of health care, including planning, delivery, financing and regulation. However, the increasing number of expatriates living in GCC countries strained the capacity of the public sector. As a consequence, Governments decided to provide treatment free-of-charge to nationals only, and encouraged the private sector to supplement public health-care provision. This was implemented by improving the legislative environment for private sector participation and providing financial incentives for private investors.[15]

In many countries of the region, households largely bear the financial burden for health care (figure 10). In the Sudan and Yemen, private households bear the bulk of health expenditure, reflecting limited availability of public services free-of-charge and limited availability of health insurance. In Egypt, free public health-care services are available, but more than 60 per cent of health expenditure is borne by private households. The high share of private expenditure reflects either low coverage of the population by the public sector or the decision of many people not to make use of public services. The latter case is often called "spontaneous privatization", the increasing use of private facilities because of the poor quality of public sector facilities. In contrast, private health-care

expenditure is relatively low in GCC countries in spite of increasing privatization.

2. Public-private cooperation arrangements

In many cases, the private and public sectors do not provide services in isolation, but work through contractual arrangements or looser cooperation arrangements. State capacity then becomes even more important in order to set up adequate policy designs for private sector participation.

Formal public-private partnerships, which include a formal contractual arrangement, are the most institutionalized form of private involvement. The infrastructure is usually owned by the public sector, while the operation is performed by the private sector through a concession, or a management or lease contract. When infrastructure has to be built first, arrangements often specify that the private partner builds infrastructure and operates the project for a certain period and then passes ownership back to the public sector. Management and lease contracts are considered to involve the least degree of privatization.

Some formal public-private partnerships exist in the health sector. For example, public funds may be used to build a hospital that is owned by the Government or municipality, but its clinical services as well as other services may be under private management. The United Arab Emirates actively encourages public-private partnerships to develop both hard and soft infrastructure in health care. Abu Dhabi has already signed management contracts with several international hospitals.[16] Bahrain also plans to contract out certain hospital services.

In the education sector, there are similar options for public-private cooperation. For example, the operation and management of schools can be private, but the school itself remains a public school. Another option is that the school itself and management are private, but the Government supports the school with subsidies, targeted vouchers, scholarships, transfer payments or tax incentives. This strategy was pursued in several Latin American countries. For example in Chile, in 2003, private schools that depended on the Government for more than 50 per cent of their funding accounted for 37.9 per cent of all public and private enrolment at the lower secondary level.[17]

In ESCWA member countries, most schools are either fully public or fully private. In Egypt in 2002, enrolment at the lower secondary level was distributed as follows: 94.6 per cent in public institutions, 4.4 per cent in private institutions that received less than half their funding from public sources and 1 per cent in private institutions that received more than half of their funding from public sources.[18] However, some examples do exist. In Lebanon, during the academic year 2007-2008, 14 per cent of all students were enrolled in private schools with public financing – compared to 53 per cent in purely private schools and 33 per cent in fully public schools.[19] This is largely the reaction of the Government of Lebanon to the dominance of private schools. Kuwait also subsidizes private education, which benefits both Kuwaitis and expatriates. In 2003, 17.7 per cent of all government spending on subsidies went to education and around 22 per cent of education subsidies benefitted expatriates.[20] The Government of Kuwait is currently reconsidering its subsidy system, especially subsidies to expatriates, as subsidies increasingly strain the budget.[21]

Contracting out one element of a service or a project to the private sector while ownership remains public is a weaker form of public-private partnership. With its foreign donor-supported health-sector modernization programme, which began in 2008, the Syrian Arab Republic contracted out primary health-care and clinical services in select public hospitals to private doctors.[22]

A common form of public-private collaboration is public funding of private health-care provision.

This can be done either through subsidies from the public to the private sector or through coverage of health-care treatment in the private sector by public health insurance. Lebanon, for example, makes use of both options.[23] Tunisia covers private treatment with the public health insurance scheme. Coverage of private treatment was introduced in 2008 in response to unequal access to quality health care and the growth of the private sector. Although co-payments for private sector treatment are higher, insurance coverage reduces the payment burden on health-care users.[24] The Ministry of Public Health of Tunisia also contracts private hospitals to provide public insurance coverage for specialized treatments, such as cardiovascular interventions or organ transplants.[25]

Some countries are seeking to enhance public sector services with private services by allowing doctors to use public facilities for private services after official opening hours. The fees for those services are lower than in purely private facilities. Revenues are typically shared between the public facility and the medical staff performing the services. Allowing doctors additional income opportunities decreases the risk of doctors being attracted by the private sector. Moreover, this scheme can expand the overall availability of services. In the past, it was implemented in Iraq, where public services were offered only until 2 p.m. due to budgetary constraints.[26] Similar models are also reported from Egypt, the Sudan and the Syrian Arab Republic.[27]

3. Private financing of social services: insurance

Private insurance such as health insurance can also enhance access to social services and provide social protection. With some exceptions, insurance is still relatively underdeveloped in the Arab region because of the lack of a regulatory framework that favours long-term savings, limited long-term investment instruments and problems settling claims.[28]

Yet, private health insurance is growing in several countries of the region. GCC countries have encouraged private insurance companies to provide funding for public and private health care. Saudi Arabia established the Council for Cooperative Health Insurance in 1999 to introduce, regulate and supervise a national health insurance strategy. Insurance itself is provided by private sector companies. As a result of these efforts, contributions to private insurance plans made up 52.1 per cent of private health-care expenditure in Saudi Arabia in 2006.[29] In 2009, Saudi Arabia made private health insurance mandatory for all non-nationals and their families and the country seeks to expand mandatory health insurance to the national population as well as to pilgrims in the future.[30] In 2011, the number of insured persons in Saudi Arabia reached about 7.9 million. Expatriates accounted for 71 per cent of the insured and the rest were Saudi nationals working in the private sector.[31]

In 2006, contributions to private health insurance made up 19.9 per cent of private health expenditure in Lebanon and 22.7 per cent in Morocco.[32] In Lebanon, it can be seen as a result of a relatively well-developed insurance sector compared to other countries in the region and the dominance of private health care. In Morocco, the relatively large role of the insurance sector is attributed to a number of factors, including the historical role that the private sector has played in providing comprehensive health insurance, but also a regulatory regime that has tracked developments in the European Union and the regulator's willingness to allow foreign holdings in leading local insurers.[33]

4. The role of corporate social responsibility and corporate philanthropy

Private provision of social services for profit is not the only way in which the private sector can contribute to the provision of social services. The private sector is increasingly seen as not

only responsible for profit-making, but it is also expected to take on legal, ethical and philanthropic tasks. This includes ensuring a minimum of social protection for workers by paying fair wages or by "doing no harm" through core business actions, as well as contributing to community development through philanthropic and charitable activities and environmental protection.

The idea that the private sector has social responsibilities is not new in the Arab countries. In fact, there are overlaps between the concept of corporate social responsibility and the Islamic concept of entrepreneurship. A Muslim is always responsible to God for his or her deeds; and a Muslim entrepreneur has to act in line with Islamic principles. For example, proponents of Islamic Economics derive the duty to pay fair wages from the Koranic rule to use appropriate measurements (Sourat 17, verse 35). A hadith also stipulates that a worker should be entitled to good food and clothing.[34] Moreover, acts of charity are mandated by the Koran and are deeply embedded in Arab cultures.

A company's concerns for society could also include the provision of social services and social assistance, for example through corporate philanthropy. Following the long tradition of charity, many entrepreneurs do engage in philanthropic activities – but following a charity approach rather than considering these contributions as their responsibility to society. Entrepreneurs may practice philanthropy without explicitly reporting it, and so the extent or value of it is difficult to measure.

In 2012, the Arab Organization for Corporate Social responsibility presented an award to Zain, a Kuwaiti telecommunication company, in recognition of its activities and initiatives that focus on education, health care and the environment.[35] The company contributed to the rehabilitation of eight public schools in Jordan through the *Madrasati* Initiative (box 1). In Kuwait, it deployed a mobile care unit to treat eye diseases, and in Iraq, in cooperation with Amar Foundation, it provided literacy training to 6,550 adults and placed 50 women into jobs in cooperation with a centre for widows.[36]

Other firms in the region are also engaged in corporate social responsibility initiatives and activities. Saudi Aramco maintains its own schools using an American curriculum for dependents of expatriate employees, and also has a programme to promote the education of Saudis not employed with Aramco. Through the college preparatory programme that aims to equip students with life skills, Saudi college students can work for Aramco during the summer holidays, where they have access to courses in English, mathematics, technical skills, computer training and special safety programmes.

In Palestine, private sector companies have demonstrated their ability to provide social services in times of crisis. For example, during the Israeli attack on Gaza in 2008, the private sector provided supplies that were in shortage due to the siege, contributing with in-kind donations such as food, medical supplies and clothing. The staff of several local banks in Palestine dedicated a day's wages for the benefit of Gaza.[37]

A recent survey in Palestine of 30 private sector companies that issue corporate social responsibility reports revealed that the majority of activities targeted health and education. All of the companies were driven by religious and moral concerns, and 21 out of 30 companies believed "that the poor have a right to a share of company profits, in accordance with religious beliefs".[38] However, the authors of the survey also noted that "there is a general misunderstanding of the concepts concerning corporate social responsibility", as "some companies considered marketing activities as part of their social responsibility programme, which included activities like sponsorship of exhibitions and conferences".[39]

Box 1. *Madrasati*: an initiative to encourage the private sector to support public schools

Acknowledging that many public schools in Jordan are underequipped, Her Majesty Queen Rania Al Abdullah launched an initiative to harness corporate social responsibility to improve the provision of education in Jordan. The project targets public schools that are in urgent need of equipment. The first phase of the project is to upgrade the physical infrastructure of schools, and the second phase is to implement educational programmes within the schools that are driven by the community needs. Through this initiative, private sector corporations are encouraged to support schools financially, provide in-kind donations (such as renovation material), or encourage their employees with expertise in planning and management, or technology to share their knowledge with teachers and pupils. Similarly, private schools are also encouraged to partner with the selected public schools and support them through fundraising initiatives, training teachers and encouraging interaction between students of public and private schools.

Several large private sector companies as well as NGOs participate in the programme. In the long term, they can benefit from improved educational outcomes in Jordan by better aligning curricula to the needs of the labour market.

By 2012, the infrastructure of 500 schools that participated in the programme had been upgraded. In some schools, private sponsors also enabled the refurbishment of school facilities to make them accessible to persons with disabilities.

Source: www.madrasati.jo.

Although many companies in the region are engaged in charitable and philanthropic activities, these are often ad hoc. Moreover, the approach to corporate social responsibility that includes the internal practices of the firm, such as paying decent wages, is less prevalent in the region.

Another difficulty with corporate philanthropy is that it often lacks sustainability. Partnerships between private companies, civil society and the Government can ensure sustainability and encourage activities based on social needs. The Madrasati Initiative in Jordan exemplifies the coordinated approach to corporate social responsibility.

In a welfare mix, the role of the state is to encourage corporate social responsibility through regulations, raising awareness, providing awards and tax incentives, and encourage systematic reporting.[40] For example, Saudi Arabia launched the Responsible Competitiveness Initiative in 2008 to enhance the creation of jobs for Saudi nationals and to promote employment for women; to set higher health and safety standards in the private sector; and to promote business ethics.[41]

5. Social entrepreneurship

The social enterprise is a new form of strategic philanthropy that invests in social change. Unlike civil society, the social enterprise has to include a strategy for achieving financial sustainability, such as earning income, and should pioneer change and contribute to more "systemic" change.[42] The difference between a commercial private sector company and a social enterprise is that for the former, profit is the ultimate goal, while for the latter social change is the ultimate goal. Profit can be a means to achieve the goal of a social enterprise.

Social enterprises can take different legal forms and organizational models, ranging from social businesses that are registered as for-profit

companies to leveraged non-profit organizations, which do not have an income-earning strategy but have "secured sustainable partnerships and funding to move beyond the traditional donor-dependent model".[43]

One example of a social enterprise in the Arab region is the Education for Employment (EFE) initiative in Egypt, Jordan, Morocco, Palestine, Tunisia and Yemen. The vision of EFE is "… to empower youth with the skills and opportunities they need to build careers that alleviate poverty and create a better future for themselves, their communities, and the world."[44] The organization identifies skills that are most in demand by the private sector and provides training for young people to develop those skills. The organization wins commitment from private companies to hire the graduates of the programme. Since its initiation in 2006, EFE has created public-private partnerships to improve education in the countries where it operates. The project trained 3,000 young people across the Arab region and placed them into jobs.

Another example is Al Jisr in Morocco, an initiative to reform the Moroccan education system by forging partnerships between the private and public sectors. Part of the initiative is the "school adoption" programme, where private sector companies can adopt the school and improve infrastructure, equipment and the quality of teaching.[45]

B. What can the private sector offer in a welfare mix?

The private sector has several strengths that can contribute positively to the welfare mix, especially if its participation is accompanied by adequate social policies that mitigate risks, and regulatory oversight that ensures quality and equity of access to services it provides. Examples in this section will illustrate some of the strengths of the private sector in the welfare mix of ESCWA member countries.

1. The private sector can fill gaps where public sector capacity is limited

Due to armed conflict or budgetary constraints, the public sector may not possess the capacity to provide an extensive range of social services. As demand for these services persists, the private sector is likely to step in to fill the gap.

In Lebanon, for example, public provision of social services came almost to a halt during the civil war. Other actors in civil society and the private sector filled these gaps, providing health care, education, and even water, sanitation and housing. In fact, Lebanon had a long tradition of civil society involvement in the provision of social services, predating the civil war. As a result, non-state actors had the capacity to step in when conflict interrupted public service provision.[46]

Another example is the health sector in the Sudan, where, due to reductions in public spending since the 1980s, even more gaps emerged in public sector provision, which were partly filled by the private sector. Private sector participation became essential to meet the health-care demands of almost all income groups, not only wealthier individuals.[47]

The private sector can also pioneer the provision of certain services, the demand for which the public sector may not have foreseen. Although most ESCWA member countries provide public education at the primary and secondary level, public preschool education is almost non-existent in many countries. The private sector has begun to fill those gaps. In Oman, for example, preschool education is almost entirely private, typically attached to a larger private school.[48] In Jordan, preschool education has developed through private sector initiatives, often driven by the demand of parents. Private preschools have

Box 2. Private sector provision triggering government action in Jordan

In some cases, the private sector can serve as a catalyst to trigger government action. Successful private sector initiatives can encourage the Government to follow suit. In Jordan, the private sector, including civil society, pioneered the development of preschool education. Demand for preschool education in Jordan quickly expanded. The Government also realized that children who had attended preschool typically performed better at elementary school than children who had not. To expand the availability of preschool education, the Government started in 1996 to develop policies to encourage the preschool education sector through both public provision and further encouragement of the private sector.

The Government also realized that access to private preschool education was mainly limited to wealthier urban population groups. Thus, it undertook efforts to enable access to preschool education for children in lower income groups by integrating preschool education into its public school system. For example, it mandated underutilized public school facilities for use as preschools. As a result of the Government efforts, by 2008 the number of public preschools had reached almost 600. The Government also sought to ensure the quality of private preschools by introducing licensing and accreditation standards.

Source: UNICEF, 2008, pp. 31, 75 and 90.

often taken the form of non-profit organizations, which had to be financially self-reliant. In 2006, about 77 per cent of kindergarteners in Jordan attended private schools.[49] The success of private preschool education persuaded the Government to start providing public preschool education (see box 2). Morocco, realizing that the public sector would not be able to provide preschool education, passed a law in 2003 that defined the provision of preschool education as the responsibility of the private sector, while the Government intended to focus on regulation, training and pedagogical innovation.[50] In the Syrian Arab Republic, demand for preschool education has been on the rise in recent decades due to the increasing numbers of working women, particularly in urban areas. In response, the Syrian Government amended the law that had restricted private schools in 1991 and allowed private preschools on a fee-for-service base.[51]

2. The private sector can fill quality gaps left by the public sector

It is often argued that the private sector is able to provide services of better quality than the public sector given its larger financial capacity, but also as a result of more efficient management. As the private sector is able to pay higher wages, it attracts better-qualified and possibly more motivated staff.

The present chapter discussed examples where the private sector is able to provide services which are often perceived as services of higher quality than those of the public sector. In some cases, quality does not necessarily mean the measurable quality of services, but rather refers to the perception of quality, including customer service. Private schools are often able to use different pedagogical methods or, due to their greater financial capacity, are better equipped than many public schools.

The perceived poor quality of public sector health services pushes users to turn to the private sector, even though they have to pay for it out of their own pockets. In the Sudan, a survey revealed that the limited availability of qualified physicians and long waiting times were the main complaints about public sector services. The survey also found that 72 per cent

of patrons of private hospitals agreed that they had "trust and confidence in the services" and 60 per cent perceived the overall quality as higher in private hospitals than in public ones.[52] In the Syrian Arab Republic, the shorter waiting time at private hospitals and clinics is a main asset of the private sector.[53] In Egypt, regardless of age or gender, people cited more personalized and better quality of services as the main reasons for their preference of the private sector.[54]

In several countries of the region, public health-care facilities are insufficiently equipped. Due to the private sector's larger financial capacity, specialty care has become available in almost all countries of the region through the private sector. For example, according to data from 2004, in Tunisia, the private sector is generally better technologically equipped than the public sector. While there were 54 computer tomography scanners in private health-care facilities, there were only 20 in public health-care facilities.[55] In Jordan, the advanced equipment used by the private sector is considered one of its strengths. In both Jordan and Tunisia, the State strives to harness the potential of the private sector by contracting out certain services to the private sector, to relieve the public sector of the burden of investing in new and costly technologies.

3. Private sector services can complement public services for certain groups

The private sector can sometimes also provide services for those who are, for various reasons, excluded from public provision. For example in the Maghreb countries, private for-profit schools are often founded to offer an option at the secondary level to those who were excluded by the highly competitive public school system.[56] Most enrolment in these private for-profit schools comes from the middle class. In the absence of private alternatives, these students would have to search for a job or, given high unemployment, take up an occupation in the informal sector.

Several social enterprises specifically aim to complement public sector services or, similar to civil society, specifically target groups that are not reached by the public sector or the commercial for-profit sector. One example is "Skoun" in Lebanon, the first outpatient therapeutic facility that offers prevention and treatment to drug users in several areas of Beirut. While there is a charge for services, the company's income in 2011 was mainly derived from public and private donations, as well as fundraising galas.[57]

4. The private sector can better react to emerging needs through greater flexibility

Vocational training provided by the public sector has often been ineffective in providing the skills needed by the private sector. Among the reasons cited for this is that the curricula set by ministries of education often lack the flexibility to respond to emerging needs in the labour market.[58] The private sector has comparative advantages in the provision of vocational training, as it can adapt its curricula to the needs of the job market. In Egypt, there are both public and private providers of vocational training. The quality of vocational training by private providers tends to be higher, because private providers use market-driven curricula, modern training methods and trainers with adequate technical and pedagogical qualifications.[59] In Tunisia, the Government considered private providers of vocational training as those who would be better able to bridge the gap between education and employment. Thus, with decree 2007-4174, it began to support the private sector in vocational training, especially in underdeveloped regions, with partial government funding through training cheques. The first training cheques were issued in 2011.[60]

Due to greater flexibility, private sector schools are often able to teach in foreign languages or give greater emphasis to learning foreign languages than public schools. As foreign language skills have become a key requirement for well-paid jobs

in the private sector in many Arab countries, this flexibility is often considered an asset of private education. For example in Egypt, so-called "language schools" offering classes taught in a foreign language (usually English) have become increasingly popular in recent years.[61] Similarly, foreign diplomatic schools in Morocco and Tunisia, where the main language of instruction is French, are becoming increasingly popular among the urban upper class.[62] The increase in the number of private French companies in Maghreb countries, as well as the high success rates in exams of foreign diplomatic school students, are considered among the key drivers of this trend.

The greater flexibility accorded to private education may even spearhead social change. In the past, Saudi Arabia tacitly tolerated girls' sports in private schools, and in May 2013, it was officially permitted, although it is still forbidden in public schools. According to media reports, girls' sports in private schools are considered a pilot project, with the aim of expanding them to public schools in the future. With the new decision by the Ministry of Education, private schools are obliged to provide appropriate space and equipment for sports.[63]

C. Critical issues in the provision of social services by the private sector

The section above has shown that the private sector has the ability to fill the gaps left by the public sector, whether in the quality or quantity of services. But there are critical issues that have to be considered when the private sector plays a role in the fulfilment of human rights.

1. Equity in access to services

The main concern when the private sector provides social services is equity of access, because those who are not able to pay cannot access services. Other financing mechanisms such as social health insurance or government subsidies may be available, but even access to those mechanisms may be unequal. Several examples outlined below demonstrate that it is mainly the wealthier segments of the population who can afford social services from the private sector. In cases where the quality of the public sector lags behind the quality of the private sector, there is a risk of a two-tier system, where those able to pay can afford quality private sector services, while the rest are forced either to accept lower quality public services, or to reduce household expenditure in other areas to gather sufficient funds to pay for quality services.

Private education is often a privilege of higher income groups and tends to reinforce socioeconomic stratification. For example, according to a household survey undertaken in Egypt in 2005 and 2006, 24.3 per cent of the highest income quintile attended a private school, while at best 5 per cent of other income quintiles attended a private school. Lower income groups are most likely to enrol in government schools, but they also make up the largest share of enrolment in private, religious Al-Azhar schools.[64] This leads to a situation where the wealthiest quintiles have better access to the kind of education which is needed for better-paying jobs. Similarly, in Jordan, according to household surveys undertaken between 2001 and 2006, 22 per cent of children from high-income households and 10 per cent from higher middle-income households were enrolled in private primary schools, compared to only 2 per cent of children from lower income households.[65] A study by OECD also found that in Jordan, Qatar and Tunisia, socioeconomically advantaged students are more likely to attend private schools than the national average.[66]

Lebanon is one of the few countries in the Arab region where some private schools offer education free of charge. These schools are either subsidized by the Government or financed by civil society organizations or the private sector

through corporate philanthropy. Subsidized private education mainly targets low-income families. However, schools tend to maintain separate classrooms or even separate buildings for subsidized and non-subsidized students, which also raises concerns about a two-tier system. In addition, the number of schools supported by government subsidies has decreased over time, while the number of private schools has increased.[67]

Admission to private schools is often based not only on the ability of parents to pay, but also on the admission criteria of the school, such as academic achievement, parent endorsement of the school philosophy, or letters of recommendation. OECD has reported that social networks and personal connections play a large role in admissions to private schools.[68] Moreover, private schools tend to reject children with special learning needs, on the grounds that the school would not possess the capacity to support them. However, according to the Convention on the Rights of Persons with Disabilities (CRPD), children with disabilities have the right to be integrated into mainstream education.

As the private sector's provision of social services is often on a fee-for-service basis, the private sector may reject those who are not able to pay. This is especially severe in the health sector when, in some cases, patients with life-threatening conditions who do not have health insurance are forced to search for a hospital willing to treat them. Such a case was reported in Lebanon in February 2013. An infant died "at the doorsteps of a hospital" because hospitals refused treatment as the parents could not pay hospital expenses upfront.[69]

2. The need to shoulder high costs for quality services can lead to detrimental coping strategies

Access to quality health care is an essential human need. When it is not available free of charge or when the quality of public services is poor, households are often willing to shoulder high costs of good quality care. To cope with high costs, households may take on debt; they may have to make detrimental reductions in other expenditures (for example education). Financial strain can increase their vulnerability to price shocks.

Figure 11 shows that it is not just high income groups who make use of private sector services. In order to be able to pay for services, households sought support from family members working abroad, took loans from family, neighbours or friends, or sold assets. In Jordan, a survey showed that paradoxically, those without insurance tended to prefer private sector facilities, although they could get free or highly subsidized services at public facilities. Even those with public insurance that covers the costs of public facilities often still choose to pay for private facilities out of their own pocket.[70]

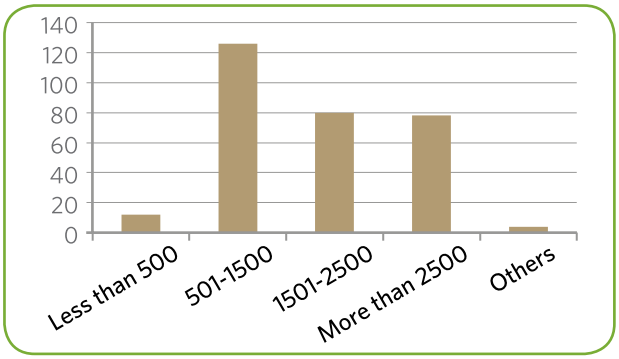
3. Inequity in service coverage

The private sector typically provides services in areas where inhabitants are able to pay, which is mainly in wealthy urban areas. In cases where the coverage of public sector facilities are also mainly concentrated in wealthy urban areas, there are concerns that poorer and rural areas are covered by neither the private nor the public sector.

In several countries of the region, private health-care facilities are concentrated in urban areas. In Tunisia, 79 per cent of private general practitioners are in Greater Tunis and the eastern central region.[71] Similarly, two thirds of private hospitals in Iraq are in Baghdad.[72] To date, private sector participation in health care in the Sudan is still concentrated in wealthy urban areas of Khartoum and Gazira, where public facilities are also concentrated.[73] The distribution of physicians is similarly unequal in Egypt.[74]

By contrast, the strategy of the Government of Jordan encourages complementarity between

Figure 11. Monthly income of surveyed users of private sector health-care services in Khartoum (*Sudanese pounds*)



Source: Saeed, 2011, p. 29. Note: US$1=5.52 Sudanese pounds.

the private and public sectors. The Government encouraged the private sector to enhance its services for wealthy urban areas and expanded public services for rural and poorer areas.[75] Coverage of public sector health-care facilities in rural areas is relatively good, involving an extensive network of village clinics.

Corporate social responsibility activities tend to target groups that appear to be more attractive according to the cultural norms of the Arab region. As there are no mechanisms to regulate corporate social responsibility activities, this can lead to their concentration in specific sectors or target groups that are already relatively well covered by existing services, while others remain underserved. They provide support to widows and orphans, or generally focus on services that can be combined with marketing goals.

4. The private sector can undermine the overall efficiency of the system

Another risk is that the private sector can siphon off human resources from the public sector, thereby undermining it. This has been reported, for example, in the health sectors in Iraq and Tunisia, where the public sector began facing personnel shortages because doctors preferred to work in the private sector, attracted by higher salaries. In order to create incentives for doctors to stay in the public sector, many countries allow them to have a second job in the private sector to add to their public sector salaries.[76] Countries may also allow public-private cooperation arrangements, in which doctors use public facilities for private consultation times, as explained earlier. However, these schemes create incentives for doctors to encourage patients who come during public hours to revisit them during private working hours, thus undermining the effectiveness of the public sector.

In the education sector in Egypt and Morocco, equity concerns arise from private side activities undertaken by teachers, which reduce their motivation to perform in the public sector. In Morocco, a concern evolved in recent years that teachers started taking up a job in a private school in addition to their job in the public sector, which led the Ministry of Education in 2012 to impose restrictions on public school teachers against taking up a second job. In turn, this led to concerns about the limited availability of teachers in the private sector.[77] In Egypt, a large number of teachers top up their public school salaries with private tutoring. This practice is often seen as a result of the emphasis on the results of end-of-the-year exams and rote learning, combined with low pay for public school teachers. In the worst cases, teachers do not even teach the full syllabus during official classes, thus forcing students to take private lessons.[78] This practice further decreases the quality of public sector education, and exacerbates inequalities and forces households to shoulder high costs for private tutoring.

5. Efficiency and quality cannot always be taken for granted

Although the private sector is often associated with greater efficiency, it cannot be taken for granted. In fact, when incentive structures are not set up adequately, the private sector can

also operate inefficiently. For example in terms of health care, the private sector may have a tendency to overinvest, overdiagnose and prescribe expensive brand-name medications. In Lebanon, health reforms including an accreditation system, a national regulatory authority and a database used to monitor public and private health provision have contributed to higher utilization rates and lower public spending on health. This example suggests that increased regulation can have positive effects in the health sector.[79] In 2005, health expenditure amounted to 11.9 per cent of government expenditure due to overbilling and overtreatment in the private sector.[80] Public funding has also fuelled the establishment of private hospitals, many of which are so small that they would not be viable without public funds because they cannot achieve economies of scale. The quality of treatment in small hospitals also remains a concern. Doctors are expected to be generalists, but have little experience in certain specialized operations or treatments.[81] In recent years in the United Arab Emirates, there has been a tendency to over-utilize insurance schemes and over-consume highly priced private medical care. That trend has contributed to driving up the costs of health-care treatments by 30 to 40 per cent between 2008 and 2011.[82]

Similarly, it is not always the case that private sector services are of better quality than the corresponding public services. In many countries of the region, especially in GCC countries, education has become a sought-after investment market with expected returns on investment of 10 per cent,[83] which raises the concern that profits, not the well-being of children, are the main determinant. An inspection of private schools in Abu Dhabi between 2011 and 2013 revealed that two thirds required "significant improvement". Some schools were found to neglect child safety, with overcrowded classrooms and unqualified teachers. The inspection report also found that quality was not necessarily linked to fees. There were some schools that charged low fees, but had excellent performance results.[84] In contrast to common perceptions, in Kuwait there are more students per teacher in private than in public sector education. In 2010/2011 at the primary level, the student-teacher ratio was 6.3 in public schools, compared to 18.2 in private schools.[85] A possible explanation is that in the profit-oriented private sector, schools seek to keep staff levels relatively low.

In addition, educational outcomes are not always better in private schools than in public schools. In Dubai, students from grades 4 to 7 in private schools using the national curriculum performed slightly below students from public sector schools in international standardized tests such as TIMSS, but both performed lower than most foreign-curriculum private schools in Dubai.

D. Monitoring and regulation of the private sector provision of social services

Regulation of the private provision of social services is important to enable the private sector to contribute positively to the welfare mix, while ensuring quality and equity in access and coverage. It is also important to find the right balance and avoid overregulation, which discourages private sector activity.

The level of monitoring and regulation of the private provision of social services within the region varies by country and across sectors: while one sector can be heavily regulated in a given country, regulation may be limited in other sectors. The type and amount of regulation in a country usually depends on whether it actively designed a role for the private sector in the provision of social services or if the private sector spontaneously stepped in to fill existing gaps in service provision.

The lack of a regulatory framework can have the consequence that the private sector emerges largely without public sector regulation. Overall it appears that some efforts are being made to regulate quality through licensing and accreditation, but there is relatively little regulation to ensure equity of access. Price regulations exist in some cases, but they tend to benefit the middle class more than lower income groups, because prices for private sector services are still too high for many low-income households to afford.

Part of the existing regulation is supposed to encourage philanthropic activities within the private sector, for example through tax incentives. Jordanian law allows for the deduction of philanthropic donations of up to 25 per cent of the total taxable income. The Egyptian tax law of 1994 even allows deducting donations and assistance to the Government, local authorities and public bodies. This was done to encourage private funding for community projects. However, many companies do not make use of potential tax deductions, partly because of lack of knowledge of this possibility.

In the aftermath of the civil war, health-care services in Lebanon were mainly provided by the private sector, including civil society, with limited public sector facilities. In order to increase equity of access, the public sector provided financing for private health-care delivery. However, this strained the Government's budget due to overbilling by the private sector, as described earlier in the chapter.

In order to address overbilling in private sector care and to ensure quality standards, the Ministry of Health introduced several reforms and regulations. For example, in 2000 it introduced flat rates for consultations and surgical procedures. In 2005, it introduced a financial ceiling for each contract with a hospital, which allowed more efficient control over expenditures and discouraged hospitals from overtreating. These regulatory reforms, in addition to improving the quality of public sector care, have simultaneously reduced public health spending and reduced out-of-pocket health expenditures.[86]

Some countries in the region, especially in the GCC, designed an important role for the private sector in delivery of both health and education and established an independent regulatory authority to regulate quality and pricing in both sectors. Bahrain plans to give a larger role to the private sector in health care in the future, while the State will concentrate on regulating and monitoring. To this end, it established the National Health Regulatory Authority (NHRA) in 2009 to carry out all monitoring and regulation activities in the health sector.[87]

Emirati Decree No. 1 of 2007 established two regulatory agencies: the Health Authority of Abu Dhabi and the Dubai Health Authority. The Health Authority of Abu Dhabi "… shapes the regulatory framework for the health system, inspects against regulations, enforces standards, and encourages adoption of world–class best practices and performance targets by all healthcare service providers in the Emirate". It regulates quality through accreditation of health-care facilities and professionals. For example, all health-care professionals must obtain a license prior to practicing in a health-care facility in Abu Dhabi.[88] Licensing requirements for hospitals in Dubai are very detailed with specific requirements about hospital design, including requirements for disabled access and quality of care standards.[89] In spite of these efforts, the overall health-care system still has to move towards standardization across the Emirates. Medical personnel licensed in one Emirate are currently not allowed to practice in another. Moreover, licensing processes for hospitals are perceived as cumbersome, and have contributed to increased health-care costs.[90]

In Lebanon, an accreditation programme has become a prerequisite for hospitals to

Box 3. Regulation of private education in Dubai and quality outcomes

Dubai established the Knowledge and Human Development Authority by Decree 2006/30 of 2006 to regulate "growth, direction, and quality of private education and learning in Dubai".[a]

To control quality, the Knowledge and Human Development Authority undertakes annual inspections of private schools. These assessment reports are published on the Internet.[b] Among the assessment criteria are students' academic achievements, their social behaviour and how the school integrates children with special education needs.

Through the regulation of school fees, the Government of Dubai seeks to protect parents and students, but also to ensure a favourable investment environment for the private sector. The regulatory authority links school fees to the quality of education as assessed by the Dubai Schools Inspection Bureau and sets maximum fees. Approved fees are based on the educational cost index, which is calculated and announced annually by the Dubai Statistics Center. There are six tuition-free private schools and very low-fee private schools that charge approximately US$470 (1725 dirhams) per year. On average, annual tuition fees in Dubai were approximately US$4,954 (18,196 dirhams) in 2012/2013.[c] Thus, in spite of price caps, many private schools remain unaffordable for lower income groups.

The Knowledge and Human Development Authority also seeks to encourage the integration of children with disabilities into mainstream schools. After the Authority learned that many private schools rejected children with special needs, it included the schools' ability to integrate special needs into its quality certification criteria in 2010. As a result, more private schools started accepting children with special needs.[d]

Sources: [a] http://www.khda.gov.ae/Pages/En/aboutkhdaen.aspx.
[b] http://www.khda.gov.ae/En/DSIB/Reports.aspx.
[c] Knowledge and Human Develpment Authority, 2013, p. 17.
[d] Ahmed, 2011.

contract with the Ministry of Public Health. The accreditation system examines quality of medical care and hospital management. As a result of the accreditation programme, the quality of hospitals has improved because the new system provides better incentives. The challenge will be to maintain quality even after hospitals have obtained accreditation.[91]

Dubai takes a similar approach to the regulation of private education with an independent regulatory authority (box 3).

Egypt also seeks to reform its regulatory landscape in the health sector and introduce a regulatory body. In 2010, Egypt planned to introduce an independent regulatory and accreditation body to ensure quality.[92] The Ministry of Health should facilitate private initiatives to empower the health-care sector rather than serving as a provider of health-care services.[93]

While regulation is meant to ensure quality and equity of access, heavy regulation can also limit opportunities to harness the strengths of the private sector. In Egypt, for example, the education sector is heavily centralized and controlled by the Ministry of Education. Teachers must follow material provided by the Ministry of Education with little room to structure lessons in different ways.[94] Furthermore, admission to universities, especially to the preferred faculties such as medicine and engineering, is entirely dependent on results in the secondary leaver's

exam. In turn, success in these exams is mainly based on rote learning and not on cognitive skills.[95] Thus, private schools have relatively little room for manoeuvre, as they are still bound by these regulations, which diminish incentives for innovative pedagogical practices.

E. Summary

The discussion in this chapter has shown that private sector contributions are already a reality in the welfare mix of most ESCWA member countries; however, the levels and degrees of private sector involvement vary.

Many countries in the region have in the past strived to be the planner, provider, funder and regulator of all social services. But this system has become increasingly challenged, with different consequences in different countries. In Egypt, Iraq, Jordan and Lebanon, gaps led to the spontaneous privatization of social services, where the private sector started to fill gaps without significant regulation by the Government. In some cases, such as in Lebanon, regulation came only as a reaction to inequity in access or quality concerns. Other countries, especially GCC countries, seek to bring the private sector in more systematically, by designing policies that encourage private investors and establishing a regulatory environment for the private provision of social services. Some countries, such as Tunisia and Morocco, also took a more systematic approach, promoting private sector participation in some sectors, such as health, while retaining a strong hold on others, such as education.

The private sector has contributed to a larger variety and depth of social services in many countries by providing services that were or are almost non-existent, especially in situations of armed conflict. By filling market niches, the private sector also provides services that the public sector has not planned, such as preschool education. Private sector actions can also serve as pilot projects for the public sector and trigger policy change.

In most cases, the main beneficiaries of social services provided by the private sector seem to be wealthier income groups in urban areas. Rural areas are rarely served by the private sector, whether in terms of health or education. But generally, more research should be done on the beneficiaries of services provided by the private sector, including the beneficiaries of social enterprises, as little information is currently available.

In cases where adequate, free of charge or low-cost public health-care facilities are scarce, even households from lower income groups make use of private health facilities, as health is an essential human need. Low-income households may also prefer to seek treatment in private facilities due to quality or coverage gaps in public service provision. In order to afford access to private health care, they often have to take out loans, make detrimental reductions to other household expenditures such as education, or both. A major concern about the current welfare mix in many countries of the region is that it exacerbates a two-tier system where higher income groups in urban areas have access to a good selection of high-quality social services, while low income groups in rural areas are left with a limited choice of social services, often of low quality. Civil society has partially filled certain gaps in quality, which has raised a series of new considerations that will be discussed in the following chapter.

State intervention may therefore be necessary to ensure equitable access to quality services. Some countries are already seeking to strengthen regulation by establishing an independent regulatory body. Until now, regulation has focused primarily on ensuring quality through accreditation or licensing procedures, or in the case of education on setting national curricula.

However, when national curricula are too rigid and do not address the needs of the labour market, it can create a mismatch between the skills of graduates and the needs of private sector employers.

Regulation to ensure equitable access is more difficult to achieve. Current measures applied to regulate prices are usually price caps such as those imposed on private education in Dubai, or by introducing flat rates, as was done in the health sector in Lebanon. However, these price regulations mainly benefit those who, in principle, have the ability to pay for private services; the costs of which remain unaffordable for low-income groups. Thus, price regulation disproportionately benefits the non-poor.

The question then remains how the public sector could fulfil its role as a guarantor of the right of access to basic social services. When considering how to regulate the private sector, countries also have to carefully assess their regulatory capacity. Experience with regulation in several developing countries has shown that enforcement mechanisms for laws and regulations are relatively weak. Moreover, introducing a regulatory authority also requires adequate staffing with qualified personnel, which may be difficult to achieve in some countries. Moreover, the bargaining power of the state vis-à-vis the private sector is often weak. Especially in high-risk business environments characterized by political instability and red tape, Governments are often more concerned with how to provide a favourable business environment than with imposing additional regulations on the private sector that would ensure equity in access.

The role of the state as a planner will become a key factor in the welfare mix. For example, through adequate planning, the state could concentrate on providing basic social services in areas less covered by the private sector. In the health sector, specialty services could be provided by the private sector and the state could fund treatment for low-income groups. In addition, in its role as a planner, the state could encourage partnerships between the public and private sectors and civil society, to improve the provision of social services and to combine the strengths of each actor. By doing those things the state could exercise its role as a guarantor of rights.

Another option worth considering is to encourage corporate social responsibility through decent wages and "doing no harm", which would already contribute to social protection. As part of corporate social responsibility, the private sector could contribute to the funding of public sector services through a clear and coherent strategy. Coherent partnerships between the Government, private sector and civil society may have the potential to encourage corporate social responsibility and to mobilize private sector contributions.

As the private sector already plays a large role in the welfare mix of countries and is likely to expand, the main question will not be whether and how the private sector could be brought into the welfare mix, but rather how the welfare mix could be designed to ensure equity of access, coverage and quality for all. Civil society groups that may have the capacity to provide services to underserved population groups are an indispensible part of the picture and will be discussed further in the following chapter.

Chapter IV

IV. CIVIL SOCIETY AND ITS ROLE IN THE PROVISION OF SOCIAL SERVICES

The provision of social services by civil society organizations has a long tradition in ESCWA member countries. Prior to the building of modern nation States, social services were mainly provided by civil society: mosques had an important role in providing education by teaching the Koran. This promoted basic literacy, while deeper education was the privilege of the upper classes. Social services, such as schools, hospitals, orphanages, soup kitchens and even infrastructure, were mainly provided through religious endowments (waqf; plural *awqaf*).

In traditional Muslim societies, zakat (the obligatory Muslim wealth tax), waqf and *sadaqa* (charitable donations) formed a system of charity and philanthropy that promoted community-driven initiatives for social protection. While waqf generally goes towards community development, such as hospitals, orphanages, schools, water and sanitation systems, or other infrastructure, zakat and *sadaqa* can contribute to social assistance for the poor. Receiving zakat has been established as a right for clearly defined recipient groups in the Koran.

Kinship ties are of high importance in Arab societies, as well as in many other developing countries. In traditional Arab societies, people mainly turn to their families, tribal or religious leaders when in need; the call for support from the state was less prevalent in earlier times. However, when modern nation States were built, the state sought to become the main provider of social services, which was also supposed to create a strong sense of belonging, transferring allegiance from the family or tribe to the "nation". However, as shown in chapter two, these systems often left gaps in quality and coverage. Due to a number of circumstances, ranging from armed conflict to periods of economic liberalization to fiscal pressures, the family and religious institutions became more relevant to the provision of social services, although in more institutionalized ways.

While in some countries, Governments designed policies to encourage the provision of social services by civil society, in other countries civil society participation developed more spontaneously. Civil society provision of social services is most relevant in Egypt, Jordan, Lebanon and Palestine. The situation seems to be similar in Morocco and Tunisia but more research is needed to explore it in greater depth. In Lebanon, it has a long history and gained increased relevance as a result of the breakdown of state services during the civil war. In other countries, civil society provision was at times encouraged by the Government. In Egypt during the 1980s, the Government liberalized registration for NGOs, realising that the reduction of government spending for social services would leave gaps which could be filled by civil society. Yet, in the 1990s, the registration of NGOs was again subject to tighter controls.[1] In other cases, the role of civil society was also

promoted by foreign donors, as occurred in Palestine following the creation of the Palestinian Authority. The Palestinian Authority specifically recognizes the important role of civil society in the provision of social services.[2]

The provision of social services by civil society is also relatively limited in GCC countries, although some countries seek to harness traditional instruments such as the waqf and mobilize private foundations to strengthen government policy.

Many different civil society organizations are providing social services in ESCWA member countries, ranging from traditional faith-based organizations of different denominations and faith-based political movements or parties to private foundations, secular or international NGOs, and others. Faith-based civil society organizations seem to be more prevalent than their secular counterparts in the region. They often have extensive networks promoted by religious institutions, and the services they provide are often considered to be highly effective. The presence of political parties in the provision of social services, especially in Lebanon, may be a particular feature of the Arab region.

Many civil society organizations provide social services on non-profit basis without commercial interest. Thus, civil society organizations could be best suited to provide services at affordable prices to those who are reached by neither the public nor the private sector. As many civil society organizations are motivated by charitable goals, they can be relatively cost-efficient, because they are able to draw on dedicated staff willing to work for relatively low salaries. The question is then if civil society is actually able to reach those who are reached by neither the public nor the private sector.

The size of the contribution of civil society to the provision of social services is difficult to estimate, due to the limited availability of data. This chapter will take an actors-oriented approach to exploring how civil society organizations contribute to the welfare mix in Arab countries, the strengths of civil society in a welfare mix and the critical issues facing civil society provision of social services. This will be followed by a short discussion on how civil society provision of social services is currently monitored and regulated by the state and a summary.

As there is a wide range of civil society organizations and many of them cannot be easily classified, this chapter does not intend to give an exhaustive picture of all civil society services that exist in the region. Instead, it provides specific examples of civil society provision and discusses which issues arise from it from the perspective of a rights-based approach and what this implies for the overall welfare mix. Due to data limitations, examples focus on a limited set of countries where civil society plays a particular role in the provision of social services and social assistance, and where data and information have been widely available.

A. Taxonomy of civil society in the provision of social services

1. Faith-based organizations

Religions or faiths are typically not just belief systems, but specifically emphasize values such as mercy and altruism. Consequently, they form social systems with strong incentives to practice these values. It should therefore come as no surprise that faith-based organizations are active in the provision of social services, especially those targeting the poor. Essential human needs such as health-care services have always been within the purview of faith-based organizations. Initially, hospitals were entirely provisioned by charities, as hospital care was viewed as being for the poor, while wealthier people sought treatment from doctors coming to their home.

Faith-based organizations can include religious institutional bodies such as churches, but also political parties or sociopolitical movements that base their operations and/or target group on their faith. It also has to be noted that many faith-based organizations or political parties often have a closely knit network of affiliated organizations, which is not always evident to outsiders. The lines between faith-based organizations and other civil society organizations may not always be easy to draw.

The large diversity of faith-based organizations might be particular to ESCWA member countries, due to the diversity of sects, but also because of the connection between religion and politics. The patterns of service provision are relatively similar across all denominations: most provide health and education services or provide cash and in-kind transfers, thus meeting the needs of society. One difference between Islamic and Christian welfare may be that Islamic organizations tend to rely more on local funding and/or connections to organizations in other Arab countries, while Christian organizations tend to be more embedded in global networks.[3]

This section will first discuss direct services that organizations provide, often against fees for health care and education, and will then discuss the charitable activities of faith-based organizations, which are usually cash and in-kind transfers.

(a) Direct provision of education by faith-based organizations

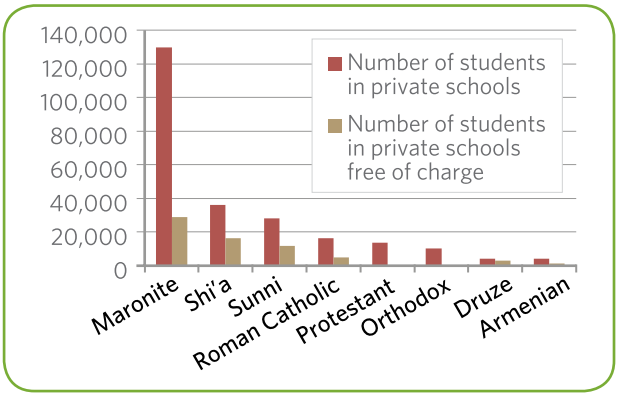
Chapter III has already discussed how education provided by civil society is mainly classified as private education. There are very few measurable statistics on the contribution of civil society to education as a whole. The contribution of civil society also varies by country in the region. In GCC countries, private education is dominated by commercial providers, whether operating on a for-profit or a cost-recovery basis. In other countries, faith-based organizations play a large role in the provision of education, including elementary and secondary schools, but also vocational training or other courses to different target groups.

Lebanon stands out as a case where faith-based organizations play a particularly large role in the provision of education. This can be traced back to Article 10 of the Constitution, which guarantees all religious denominations and sects the right to maintain their own schools. Forty-one per cent of private schools in Lebanon are maintained by faith-based organizations, representing almost all religious groups in Lebanon. The remainder are run by a variety of other civil society organizations, among them political parties or commercially-oriented non-profit organizations. The Maronite church is the largest provider of education among faith-based organizations. In 2005/2006, it maintained 18.4 per cent of all private schools, hosting 30 per cent of all students in private schools (figure 12). The second largest number of schools is attributed as "Sunnite", but there are several providers of schools to the Sunni population. One of several Sunnite providers is for example the Makassed Association, which maintains four elementary and six secondary schools in Beirut and 35 schools in rural areas, mainly in the north of Lebanon and the Bekaa.[4]

Some schools are run by political parties that are affiliated with a faith. For example Hezbollah maintains schools at the primary and secondary level, which are mainly located in the southern suburbs of Beirut, the south of Lebanon and the Bekaa valley. Overall, it was estimated in 2006 that Hezbollah's schools serve around 14,000 students.[5]

Although most of the schools run by faith-based organizations in Lebanon require the payment of school fees, a number of them are free of charge. In some cases, these schools are

Figure 12. Number of students enrolled in faith-affiliated private schools in Lebanon, 2005-2006



Source: http://www.localiban.org/spip.php?article5190.

subsidized by the Government, in other cases by the organization's own funds. The percentage of students who study free of charge is highest in Druze schools, but the absolute number is highest in Maronite schools as shown in figure 12. The schools of the Makassed Endowment Fund charge relatively low fees and a limited number of scholarships are provided.[6] The same applies to Hezbollah's schools.

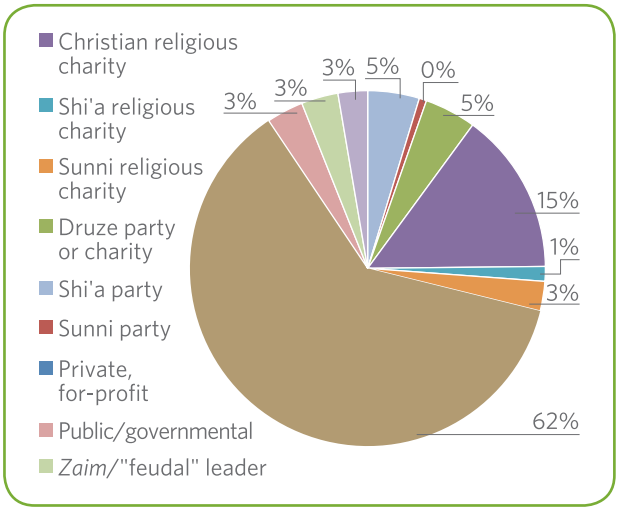
In Lebanon, where the education landscape is dominated by private schools that are largely run by faith-based organizations, it is not only the upper income groups who send their children to private schools. Due to the large civil society presence, there are also a significant number of private schools that do not charge fees. Nevertheless, lower income groups must receive scholarships or attend subsidized schools. Muslims often attend schools run by various Christian organizations, but it is rare for Christians to attend Muslim schools. Armenian schools are typically attended by Armenians only, because they also teach the Armenian language.

Egypt is another country with a long tradition of schools maintained by faith-based organizations. The system of Al-Azhar schools predates public education in Egypt and now operates in parallel to public schools. Al-Azhar schools are publicly funded, but managed by Al-Azhar University and only open to Muslim students. Students are normally expected to pursue their studies at Al-Azhar University after secondary school.[7] Al-Azhar schools generally teach the Ministry of Education curriculum, but with a stronger emphasis on religion. In 2007-2008, 10.99 per cent of all school enrolments in Egypt were in Al-Azhar schools.[8] In addition, there are a number of schools run by various churches, mainly the Roman Catholic church, some of which have a history dating to the nineteenth century. As of 2011, the Muslim Brotherhood was running 30 schools throughout Egypt, mainly in larger cities.[9]

In Morocco, preschool education is mainly provided by Koranic schools, called *kuttab*. Before Western models of education were introduced in the nineteenth century, *kuttab* was the only form of education in Morocco, instructing children from the ages of 4 to 10 years. The *kuttab* are often connected to a mosque, but some were also specifically constructed from a waqf. After a public school system was introduced following independence, the *kuttab* began specializing in preschool education. In 1995, 88 per cent of preschool children attended the *kuttab*, while the rest attended modern private preschools. In rural areas especially, many children still attend the *kuttab* instead of a public primary school. There is a difference in quality between the *kuttab* in rural and urban areas. While in urban areas, the *kuttab* have introduced modern pedagogical methods, offer several subjects in addition to the teaching of the Koran and are relatively better equipped, in rural areas the *kuttab* still use traditional methods and teach only the Koran.[10]

In Jordan, the Muslim Brotherhood maintains several schools and a university through the Islamic Charitable Centre Society. One of the

Figure 13. Distribution of hospitals in Lebanon by religious affiliation, 2008



Source: Cammett, 2013, p. 32.

schools affiliated with the Muslim Brotherhood is the Islamic Educational College, which characterizes itself as "a leading educational institute that instils Islamic moderate educational principles based on a bilingual education within its highest standards".[11] The school is well equipped with modern facilities, including a swimming pool, computer laboratory and other equipment. According to the school's website, the annual tuition fees in 2013 for Jordanian nationals at the elementary school level were US$3,065 (Jordanian dinar 2,170), which would be difficult for low income groups to afford. The school keeps a scholarship fund and provides discounts to a limited number of gifted, needy students. The Al-Faruq Society for Orphans also runs schools that are open to children from orphan families,[12] as well as families where the father is still alive. Generally, fees paid for four children finance the education of one orphan child.[13]

In addition to elementary and secondary education, faith-based organizations also provide specialized education, such as vocational training. In Jordan, several Islamic charitable societies provide vocational training for all population groups, but the largest number of courses specifically target women. As generally women have limited access to state-run vocational training, these services fill a gap.[14]

(b) Direct provision of health-care services by faith-based organizations

The earliest hospitals in Islamic history, such as the Bimaristan Nur-al-Din in Damascus, originated as *awqaf*. With the advent of the colonial era, Christian hospitals, most belonging to the Catholic or Protestant churches, spread throughout the region and some of them are still open today. One example is the Hotel-Dieu-de-France in Beirut, founded in 1888 by an agreement between the Government of France and the Jesuits. The hospital provided health-care services throughout the civil war.

While the role of faith-based organizations in the provision of health care had declined with the establishment of public health-care systems, it has been on the rise again since the 1980s. Today, particularly in Egypt, Jordan and Lebanon, the provision of health services by faith-based organizations ranges from small dispensaries to large, sophisticated multidisciplinary hospitals with advanced equipment. A rather recent trend is that faith-based sociopolitical movements, such as Hamas, Hezbollah, the Muslim Brotherhood, or other political movements (especially in the case of Lebanon) are also providing health services.

Similar to the education sector, the health-care sector in Lebanon is dominated by non-state actors, with a large contribution made by faith-based organizations. In 2008, 62 per cent of the country's 149 hospitals were for-profit and private and 43 per cent were run by faith-based or faith-affiliated parties or organizations (see figure 13). At least 44 per cent of all clinics and dispensaries were run by faith-based organizations or parties.[15]

Hezbollah's system of service provision emerged in the 1980s. This system is often perceived as "highly organized" and services are offered mainly in Hezbollah's strongholds in the southern suburbs of Beirut, the south of Lebanon and the Bekaa valley. Many of these service organizations are legally registered as NGOs, facilitating collaboration with other organizations. Hezbollah's Islamic Health Unit operates 3 hospitals, 12 health centres, 20 infirmaries, 20 dental clinics and 10 civil defence departments, in addition to maintaining social health programmes. Through its Social Health Unit, treatment is provided free of charge to low-income groups. After management of hospitals by the Islamic Health Unit was deemed to be effective, the Lebanese Government outsourced the management of several government hospitals in south Lebanon and the Bekaa valley to the Islamic Health Unit.[16]

In Egypt, the number of faith-based charity organizations, especially Islamic faith-based organizations, and the extent of their role in the provision of health care grew throughout the 1980s. Many clinics and medical centres are affiliated with a church or a mosque that is a registered NGO, and licensed by the Ministry of Health to provide health services.[17] About 20 per cent of these Islamic charities are affiliated with the Muslim Brotherhood. A large provider is the Islamic Medical Association, an organization close to the Muslim Brotherhood, which ran 24 hospitals within Egypt as of 2011. Hospitals of faith-based organizations in Egypt have the reputation of providing good quality services to people from a variety of backgrounds.[18] Clinics affiliated with mosques typically employ only Muslims, while those affiliated with churches only employ Christians.[19] The larger hospitals are mainly located in middle class neighbourhoods of Cairo, but some also reach urban informal settlements.[20]

In Jordan, the Islamic Charity Center Society, which is affiliated with the Muslim Brotherhood, maintains a total of 18 hospitals, including the Islamic Hospital in Amman that employs 130 doctors and provides "high quality services at competitive prices using the most modern technologies".[21] Although its prices may be more moderate than those of other private hospitals, it still operates on a fee-for-service basis and requests payment upfront. There are also many smaller clinics maintained by smaller faith-based welfare organizations in Jordan.

Due to the limited overall government provision of social services in Palestine, health-care facilities provided by the Palestinian Zakat Fund as well as other civil society organizations fill important gaps (see box 4). The Palestinian Zakat Fund runs hospitals and 14 clinics.[22]

Although the majority of beneficiaries of health care by faith-based organizations may be in the middle class, several faith-based hospitals or clinics treat low-income patients free of charge, financed by donations or through a system of cross subsidies. For example in zakat committee hospitals in Palestine, zakat recipients receive treatment free of charge. There are also medical centres that generally charge fees according to the level of income.

2. Social assistance and targeted support programmes

Giving cash transfers and in-kind aid to the poor are often among the core activities of charitable organizations. This is also the case for faith-based organizations in the region. Over time, many organizations have also moved to promote income-generating projects for their beneficiaries to reduce their dependence on aid. In addition to zakat funds, there are other charitable organizations, both Christian and Muslim, that provide cash transfers and in-kind aid in the region. The modalities and methods employed to identify beneficiaries will be discussed in this section.

Box 4. Hospitals maintained by zakat committees in Palestine

As zakat committees in Palestine receive large proportions of their funding from Arab donors, including zakat from other Arab countries, their financial capacity has tended to be relatively large, which allows them to engage in projects beyond cash transfers. When it became more difficult to access quality health care in the West Bank during the second Intifada, zakat committees started to provide health-care services.

The first hospital established by a zakat committee was the Al-Razi Hospital in Jenin, opened in 1990. It has expanded significantly over the past 10-15 years and now provides all major health services except radiology, which is not allowed in the West Bank. As of 2013, the hospital has 45 beds, 18 specialist doctors, 5 general practitioners, 45 nurses and 25 paramedical staff. As the hospital now offers more medical services than the local public hospital, the Ministry of Health purchases services from Al-Razi Hospital for its patients. The hospital also serves as a referral hospital for the governorates of Jenin, Nablus and Tulkarem, and is the exclusive provider of services for refugees covered by United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) in Jenin.

Although Al-Razi Hospital provides services on a fee-for-service basis, the hospital has a policy of charging the lowest fee permitted by the Ministry of Health. It also charges reduced rates for certain groups. For example, poor families registered with the zakat committee pay only 40 per cent of the regular fees. As a consequence of its relatively low fees, the hospital does not operate on a full cost-recovery basis: 20 per cent of hospital funding comes from donations.

The second hospital run by a zakat committee, the Zakat Hospital in Tulkarem applies similar policies, with even greater discounts: poor families registered with the committee receive a 60 per cent discount and orphans a 70 per cent discount. Generally, fees are kept to a minimum. However, the hospital faces serious funding shortages, caused by reduced donations from other Arab countries. As a consequence, the hospital has even faced difficulties paying its employees.

Source: Research commissioned by ESCWA.

(a) Cash transfers and social protection through zakat and charitable donations

Zakat is a religious duty for all Muslims whose wealth exceeds a certain threshold and, broadly speaking, involves donating 2.5 per cent of one's wealth.[23] The Koran in verse 9:60 describes eight beneficiary groups or purposes entitled to receive zakat, namely the poor, the needy, the administrators of zakat, those whose "hearts are inclined",[24] the liberation of those enslaved, those in debt, "in the cause of God" and travellers in need. There is room for interpretation of who is meant in each beneficiary group and on the question of whether all groups have to receive an equal share. In some countries, such as the Sudan, zakat administration bodies took a policy decision that zakat should be mainly directed towards the poor.

As the beneficiary groups are specified in the Koran, receiving zakat is an entitlement for these groups and they have the right to claim it. In this respect, the zakat system takes up a rights-based approach, although it does not include an entitlement to an amount that would ensure a dignified life. In addition the zakat system forms part of a traditional value system; the rights it outlines are not enforceable legal rights, as required by the rights-based approach.

As zakat mostly taxes wealth such as gold and other minerals, cattle and agricultural produce,

it is expected to lead to vertical redistribution. However, the difficulty is that there is room for interpretation which wealth categories are subject to zakat and what percentage is supposed to be paid from each. As rules about which wealth categories are subject to zakat are usually derived using analogies, there may be wealth categories that are left out of the zakat system, leading to inefficiencies in the redistribution system.

Some countries in the region have sought to harness the potential of zakat for providing social assistance by establishing a centralized zakat fund. In Saudi Arabia, the Sudan and Yemen, zakat is obligatory and administered by the Government, although through different institutions. In Saudi Arabia, zakat is administered by a department in the Ministry of Finance. In the Sudan, it is collected and distributed by the Zakat Chamber (*diwan-az-zakat*), a governmental institution which was established for that purpose in 1986. In Yemen, the *diwan-az-zakat* is responsible for zakat collection only. Funds are then distributed at governorate and district levels and to the Social Welfare Fund, where they are merged with other funds used for social protection. People are still allowed to distribute 25 per cent of their zakat dues directly to recipients they deem eligible.

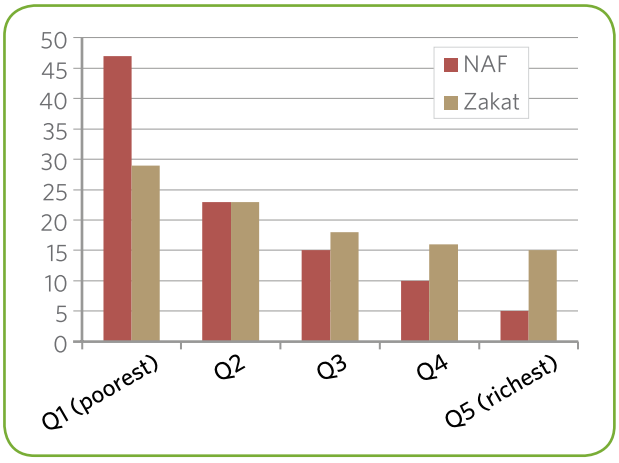
In other countries, payment of zakat is voluntary, but it is administered by a centralized fund. In Jordan, the Zakat Fund is a body established by the Government, but payment of zakat is voluntary. Zakat is complementary to other social transfers existing in Jordan. In Palestine, the Government included zakat committees as a component of the social protection strategy.[25] Palestine also established the Ministry of Awqaf to supervise the zakat committees and administer the funds they collected. Nevertheless, zakat committees are still relatively autonomous.[26] In Lebanon, there is a central Zakat Fund under the purview of the Sunni *Dar-al-Fatwa*, which is considered a civil society organization. Shiites in Lebanon pay their zakat and the *khums*[27] to several different Shiite organizations.

In Morocco and Tunisia, zakat is still paid and administered in a decentralized way through mosques, but introducing a central zakat fund is under discussion in both countries.

The income redistribution effects of zakat are impossible to track in countries where it is voluntary. Countries with obligatory zakat allow some tracking of payers and recipients. Studies in such countries, namely the Sudan and Yemen, have shown that there is no clear evidence of redistribution. For example in the Sudan, 49.9 per cent of all monetary zakat receipts in 2011 came from small and medium vendors and 35.2 per cent from agricultural crops, thus from farmers. Large businesses are, according to the report of the general auditor, the main evaders.[28] In Yemen, 40 per cent of zakat revenues in 2011 were collected from private trade and 18 per cent from "public and mixed trade".[29]

Most zakat funds offer monthly cash transfers to eligible families. Box 5 describes how eligibility is determined and verified. The Zakat Fund of Jordan gives monthly cash transfers of approximately US$42 (30 dinars) to poor income groups (without specific focus on orphans), specific aid to orphans, emergency aid, in-kind transfers and others.[30] Zakat committees in Palestine give monthly cash transfers of approximately US$27 (100 shekels) to families without a male breadwinner and other eligible poor families. It also gives seasonal donations or aid in emergency situations. Some zakat funds as well as other faith-based charitable organizations that give seasonal support such as food aid during festive seasons also play an important role. Cash hand-outs and in-kind donations are often seasonal as people tend to donate more during festive seasons. Some organizations provide cash transfers infrequently, depending on the amount of charitable donations they receive.[31]

Figure 14. Distribution of beneficiaries by wealth quintile of the Zakat Fund and the National Aid Fund in Jordan, 2008 *(Percentage)*



Source: World Bank, 2009b, p. 51.

There is actually little information available on the beneficiaries of zakat funds. Zakat funds usually publish their expenditure by programme type, but do not publish detailed data on their beneficiaries, although this data could be available given their detailed procedures and data collection to determine eligibility. According to a study by the World Bank and the Department of Statistics in Jordan, in 2008 the largest percentage of zakat beneficiaries (29 per cent) were in the lowest income quintile. But beneficiaries seem to be relatively equally distributed across income groups. However, almost half of the recipients of the National Aid Fund are in the lowest income quintile (figure 14). In 2011, the Zakat Fund of the Sudan reported that 68 per cent of zakat recipients were in the category of the poor, defined as heads of households with a monthly income of less than approximately US$22 (120 dirhams) if they are the sole breadwinner. However, detailed statistics on the actual income of recipients are not available.

In addition to cash and in-kind aid, some zakat funds also conduct income-generating projects. In the Sudan, the Zakat Chamber has adopted a policy that direct distribution of zakat should not exceed 40 per cent of donated goods or funds, and the remaining 60 per cent or more should be given to the chamber.[32] In Palestine, larger zakat committees also conduct income-generating projects. For example the Nablus Zakat Committee established a non-profit factory for dairy products to help provide stable jobs for the community and generate revenue for the Committee to help it further its charitable activities.

Overall, zakat funds and other Islamic welfare organizations seem to adopt a mix between life cycle and economic risks for their targeting, which is reflected in recipient categories such as orphans, the poor and the needy. The Zakat Fund in the Sudan defines eligibility criteria based on a combination of economic and life cycle risks, including the following: unemployment of the head of household with no other family member who is able to work; a consolidated household income below US$45 (250 dirhams); or a retired head of household with no other source of income who suffers from a chronic disease and has at least six children in the household still attending school.[33]

Although economic need plays a large role in the selection of beneficiaries of zakat funds and other Islamic charitable organizations, moral behaviour also plays a role in determining eligibility, as illustrated by examples in Jordan and Palestine. Some Islamic charity organizations even state that the ultimate goal of their operations is to make "better Muslims" out of people; they do not want to "waste their money" on people who neglect their religious obligations unless they feel that the recipient is willing to "come back on track".[34] The focus on moral behaviour may negatively affect equity of access to these services and creates room for discretionary distribution.

The procedures that zakat funds and other charitable organizations use for the selection of

beneficiaries are similar across organizations (see box 5). Both zakat funds and Islamic charitable societies often have relatively elaborate systems in place to select beneficiaries for means-tested assistance. In some cases, they also collaborate with each other and the Government to avoid duplication.

Box 5. The selection of beneficiaries by Islamic charitable organization and zakat funds

Being registered with the organization is the first prerequisite for receiving aid from zakat funds in several countries, such as Jordan and Palestine, or the Islamic Charity Center Society. In order to register, needy persons must visit the organization's office to apply for aid by filling in a form, explaining their living conditions in detail. Many organizations, including the Jordanian Zakat Fund and Islamic Charity Center Society, have social workers who follow up with a visit to the applicant's home. During the home visit, the social worker investigates the social conditions of the applicant and collects the necessary papers providing evidence of his or her social situation. For "orphan" families, data and information about the father's life and death are collected as well. The social worker also checks whether the applicant already receives aid from other sources, whether governmental or non-governmental. In such cases, eligibility depends on total income and support received by the family. The moral behaviour of orphans or families is also considered in the evaluation of the eligibility of a family. Additionally, social workers seek to confirm this information with other people who might be knowledgeable about the family's conditions, such as the chief of the neighbourhood.*

In addition to accepting applications, zakat committees in Palestine and volunteers of the Zakat Chamber in the Sudan actively identify beneficiaries on their own. Due to network contacts, they are in many cases able to identify beneficiaries who feel ashamed to apply for assistance.

*Harmsen, 2008, p. 252.

Disbursement mechanisms across civil society organizations vary. While some organizations use local banks to support cash transfers (like the Social Welfare Fund in Yemen or Zakat Committees in Palestine), or even deliver cash transfers or food aid to the homes of beneficiaries, other organizations expect beneficiaries to collect transfers from the organization. That process requires significant administrative overhead and is time-consuming for the organization and its clients: beneficiaries, mostly women, have to wait in line with documentation of their need for aid.[35] Volunteers, mostly men, verify entitlements in detail and then hand out cash or in-kind aid.

(b) Health-care financing

Faith-based organizations also contribute to financing health care, which is especially important given the high out-of-pocket payments in the region. Many charitable associations, such as the Islamic Charity Center Society of Jordan, also sponsor orphan families to seek treatment at government hospitals and clinics, paying for 75 per cent of the medical expenses for physical as well as psychological care.[36] It should be noted that this covers fees at government hospitals, but not at ICCS-run private hospitals. The Zakat Fund of Palestine and the Zakat Fund in Lebanon under the purview of the Sunni *Dar-al-Fatwa* also contribute to paying medical bills for zakat recipients.[37] In the Sudan the Zakat Fund pays contributions to the Health Insurance Fund for 500,000 of the poorest families and to 7,000 persons with disabilities in the State of Khartoum. Some organizations, such as the Anwar al-Huda Association in Jordan, use their local social networks to provide ad hoc medicine to their clients free of charge.[38] Hezbollah's Islamic Health Unit in Lebanon offers free health insurance and prescription-drug coverage through a network of local pharmacies for low-income populations, mainly Shiites.[39]

In GCC countries, charitable foundations such as the Zayed Bin Sultan al-Nahyan Charitable and Humanitarian Foundation in the United Arab Emirates, which is financed through *awqaf*, fund medical treatment for people with chronic diseases. Emiratis as well as migrant workers who have spent at least 10 years in the United Arab Emirates are eligible to apply for this programme.

3. Family associations

As pointed out earlier in this report, the family is often regarded as the core social safety net in Arab countries. In times of economic hardship, people often make use of these traditional support lines: kinship ties are used to build systems of mutual support to provide social services on demand.

Especially in Jordan and Lebanon, mutual aid associations based on kinship aim to fill gaps in social services. This means that belonging to a certain kinship is a prerequisite for membership in the association. Members of these associations pay a membership fee and services are provided to members only. Kinship associations are not comparable to charity organizations; instead, they acts as mutual insurance organizations, comparable to cooperatives.

Kinship organizations offer a variety of social services based on members' most salient needs. When Jordan cut social expenditure after 1989, even Jordanian majority groups who had previously been relatively well-covered by social services, began to form self-help groups based on kinship to have access to social protection. In Lebanon, kin associations have existed since the beginning of the twentieth century, but their number has increased significantly since the end of the civil war. During the war, militias provided social services, but they phased out those activities with the ending of hostilities. Most kinship organizations in both Jordan and Lebanon offer emergency aid. In Jordan, funeral and wedding aid are also typical services by mutual aid associations. To address the need for financial support in Lebanon's health and education sector, kinship associations in Lebanon give financial support for health care and education to their members. Financial aid is in some cases furnished as loans, in other cases as grants. Providing networks for job contacts is another feature of kinship organizations in Lebanon. In Jordan, they also maintain kindergartens and nurseries.[40]

The most successful kinship organizations are usually medium in size, with membership that is sufficient to mobilize adequate funds, but that is still small enough to monitor. Members of the more successful organizations are typically in the middle class, because they can afford higher membership fees, while poorer organizations often encounter financial difficulties.[41] Kinship associations tend to lead to horizontal equalization, as they usually involve income distribution among people in a similar income group.

4. Other civil society initiatives in the provision of social services

There are also a number of secular organizations providing social services in ESCWA member countries. The examples outlined below illustrate some of the essential services provided to certain vulnerable groups, such as persons with disabilities and refugees.

In Lebanon, about 10 per cent of all clinics and dispensaries are run by non-affiliated NGOs, while only 1 out of the country's 149 hospitals is operated by a non-affiliated NGO. This may reflect lower financial capacity of non-affiliated NGOs compared to faith-based organizations in the country.

An example of a non-affiliated NGO is Amel Association, which emphasizes its secularism and its attempts to overcome sectarian divides. The Lebanese Red Cross is another actor perceived

as neutral, non-political and non-sectarian. Amel Association cooperates with multilateral and bilateral donors and other civil society organizations. It initially focused on refugees but is now providing services for all population groups in need, and its mission is to serve the most underprivileged populations in Lebanon. The organization maintains several health clinics in different areas of Lebanon, supports preventive care through health education and provides health care and emergency services to nationals and refugees, as well as serving persons with disabilities. It provides vocational training programmes for all, including refugees, and seeks to empower people, for example through rights education. In addition the organization provides targeted education for Iraqi refugee children to enable their integration into the Lebanese education system.[42]

In almost all countries of the region, local committees of the Red Crescent Society provide health-care services and disaster relief. In Morocco, for example, they maintain several health-care clinics, including in rural areas, that provide services at discounted fees or free of charge to the poor. In Egypt, the Red Crescent Society runs primary health-care centres throughout the country that offer services free of charge or at nominal fees. In Kuwait, it supports all needy persons regardless of nationality and religious background with cash or in-kind transfers in times of financial difficulties.

In Jordan, there are a total of 136 civil society organizations providing services to persons with disabilities.[43] Some organizations specialize in helping those with specific disabilities, such as the deaf, blind, or those with mental disabilities. Most civil society organizations provide training and education for persons with disabilities, as well as transportation services. Organizations address disability from a variety of perspectives: while some focus on medical aspects, others have a charitable or faith-based background. Overall, the provision of services to persons with disabilities appears highly fragmented.

In Morocco, access of persons with disabilities to the public school system and health-care services is limited, mainly as a result of financial difficulties. Moreover, only a handful of hospitals actually meet the rehabilitation needs of persons with disabilities. These gaps are filled by civil society organizations, such as the Mohammed V Solidarity Foundation, which offers education for children with disabilities and rehabilitation services;[44] or the Al Noor Centre, which is the largest rehabilitation centre in the country for persons with disabilities. The organization Amicale Marocaine des Handicapés pays for part of the cost of equipment produced at the Al Noor centre (such as orthotics and prosthetics), in addition to financing wheelchairs and other equipment for persons with disabilities.[45]

The Sawiris Foundation for Social Development in Egypt, founded in 2001, provides human capital formation activities such as vocational training, scholarships for training and tertiary education, preventive health care, and social assistance through a microcredit programme. Human capital formation activities made up about 40 per cent of the Foundation's activities and social assistance about 60 per cent. The Foundation was set up through an endowment made by the Sawiris family and calls itself one of the "first family foundations dedicated to social development to be established in Egypt". It provides its services with a number of partners ranging from other NGOs to the private sector and the State.[46]

One example of civil society mobilization to provide high quality care free of charge is the Children's Cancer Hospital (CCHE 57357). It was the first hospital of its kind in Egypt and Africa and has become the largest paediatric cancer facility in the world, with 179 beds. It aims to achieve high international standards in its facilities

and treatment. Donations, 90 per cent of which came from within Egypt, financed the construction of the facility. To finance its operations, the hospital runs continuous fundraising campaigns and also encourages donations from the private sector through a corporate giving programme. It seeks to serve as an example of improving access to health care for all, regardless of financial status.

In Lebanon, several private foundations also provide social services. These services range from health care and education to income-generating activities such as agricultural projects. The founders of these foundations were often wealthy businesspersons and prominent political figures. Examples include the Rene Mouawad Foundation, which provides free health-care services to disadvantaged people living in remote areas of North Lebanon, and the Safadi Foundation, which conducts agricultural projects for income generation, as well as cultural and educational activities, also in North Lebanon. The Hariri Foundation for Sustainable Human Development focuses on education, agriculture and women's empowerment, among other areas. Its educational projects include two schools in Saida. The yearly tuition fee for the primary school is US$3,066 and offers full and partial scholarships.

For many years, services for persons with disabilities in Lebanon were provided mainly along faith-based or political lines. In 1984, owing to the increasing number of persons with disabilities as a result of the civil war, the wife of Nabih Berri, Head of the Amal Movement, inaugurated a centre in the southern suburbs of Beirut for the rehabilitation of persons with disabilities. This pilot project grew into the Lebanese Welfare Association for the Handicapped that opened several rehabilitation centres in south Lebanon. Later, the organization started offering secretarial and sewing courses for women with disabilities.[47] With the Nabih Berri Rehabilitation Compound, the organization now maintains a modern rehabilitation centre for persons with disabilities, offering medical and rehabilitation services and vocational training courses.

B. Contribution of civil society to the welfare mix

The examples above have shown that civil society has the capacity to provide a variety of social services, ranging from smaller charitable activities such as food donations to monthly cash-transfers or the provision of education and health care. These capacities are rooted in several key strengths, discussed in this section.

1. Civil society is often able to provide services in times of relatively limited state capacity

Especially in situations when state capacity is weakened due to armed conflict, civil society can often step in to fill the gaps.

One example is Lebanon during the civil war, when civil society began filling gaps left by the largely paralysed public sector. A number of civil society organizations were either founded or expanded their services during the civil war. Civil society has continued to play a very important role in the provision of social protection in Lebanon up until the present day, especially in terms of health care and education. It offers a middle way between public sector services and commercial private sector services, which are often not affordable for much of the population. Civil society plays a similar role in Egypt, offering affordable health-care alternatives that fall between low-quality public sector services and costly private sector services.

In Palestine, around 1,500 of the registered 2,445 NGOs provide the majority of social services, largely with support from international donors.[48] Given the limited financial resources of the Palestinian Authority, contributions from civil society are crucial for social protection in Palestine.

2. Civil society has the capacity to mobilize large financial resources to enhance the availability of social services

Civil society organizations enjoy greater trust than their public sector counterparts in many societies, through their proven ability to provide services to the people. Thus, in some cases, people may be more willing to give funds to civil society through charitable donations or philanthropic contributions than to the state through taxes.

The significant sums donated as *awqaf* in GCC countries reflect that civil society has a strong capacity to raise financial resources, which could be used for the provision of social services. For example, the International Islamic Charity Organization in Kuwait held investments worth US$118 million in 2008, which generated income of about US$4 million.[49]

Zakat funds are also able to raise and distribute financial resources for social protection that might otherwise be given in a largely uncoordinated manner, without clearly defined eligibility criteria.

Civil society organizations also apply innovative financing modes that ensure sustainability. In Egypt, for example, many hospitals and health-care clinics maintained by faith-based organizations were initially funded by endowments from wealthy persons close to the organization. After the initial endowment, the hospitals became self-reliant, operating on a fee-for-service basis. As the hospital's sunk costs were made as an endowment, the hospital or clinic can charge lower fees than the private sector, which has to factor initial investments into its fee structure. Kuwait is also trying to mobilize *awqaf* for the funding of hospitals and has developed a model where the infrastructure investment is made as a waqf and the public sector takes over the operational costs of the hospital.

In GCC countries, *awqaf* make important contributions to the provision of social services, and Governments are increasingly seeking to harness this potential. Private foundations, often established by a waqf, are frequently used to complement government policies, for example by promoting youth employment or providing social services to persons with disabilities. *Awqaf* also have the potential to contribute to income redistribution, as it is usually the wealthier income strata that are able to donate some of their assets for the sake of the common good.

In Lebanon, civil society is able to run a certain number of private schools that do not charge tuition for children from low-income families or provide scholarships. Funding stems partly from *awqaf*, including for Christian establishments, but also from other charitable and philanthropic donations.

3. Certain vulnerable groups receive services from civil society only

Civil society is often seen as best-suited to reaching marginalized groups. Among their other charitable goals, the mission of many civil society organizations is to help those who are not reached by other services. Another explanation is that many civil society organizations are formed at the grass-roots level to meet the needs of certain groups.

Zakat provides important social assistance to many low-income groups, especially in countries where no other mechanisms for social transfers are in place. For example household surveys in Yemen revealed that 35 per cent of the poorest income quintiles receive zakat. While this coverage may seem low, it is higher than that of other social transfer programmes. For those who receive zakat, the impact is significant, representing 25 per cent of their pre-zakat income.[50]

Persons with disabilities are often inadequately served by the public and private sectors. Thus

Box 6. The role of civil society organizations in promoting inclusive education in Lebanon

Persons with disabilities continue to experience substantial barriers to accessing education in the ESCWA region. According to available data in ESCWA member countries, persons with disabilities tend to experience significantly lower educational attainment rates than their peers without disabilities.

In Lebanon, the provision of education for persons with disabilities is governed by Law 220/2000. This law, considered to be one of the more progressive laws on disability in the ESCWA region, strongly supports inclusive education through provisions that guarantee equal opportunities for learning in mainstream schools (article 59) and call for formal examinations to be adapted to the needs of students with disabilities (article 62). Despite these legal guarantees, however, children with disabilities have remained largely excluded from mainstream educational settings in Lebanon. Government funding is reserved mainly for specialized schools run by NGOs under the auspices of the Ministry of Social Affairs,[a] and there is no legal imperative for mainstream schools to accept students with disabilities or to adapt to their specific needs.[b]

As a result, children with disabilities and their families largely rely on civil society organizations, including DPOs for inclusive education opportunities. One example of these efforts is the National Inclusion Project, an initiative launched by a consortium of four NGOs (the Lebanese Physical Handicapped Union, the Youth Association of the Blind, the Lebanese Down Syndrome Association and Save the Children Sweden). As part of this project, the consortium selected 10 schools, accommodating over 100 students with additional needs, to promote and support inclusive education. Approximately 120 teachers from these schools attended training workshops and were offered follow-up support throughout the year. Specialized support educators and social workers were also placed in the schools to facilitate and support the process. In addition, specialized resources including handbooks on inclusive education were prepared and widely distributed, while awareness-raising activities are estimated to have reached 300 parents and over 2,000 students.[c] Consortium members also implemented efforts to promote access to school materials, such as the Youth Association of the Blind which provides textbooks in accessible formats like Braille and large print for students with vision impairments.

Sources: **a** Based on interviews conducted by ESCWA, 5 June 2013.
[b] Khochen and Radford, 2012, p. 140.
[c] Youth Association of the Blind, 2007.

a number of civil society organizations provide services especially for persons with disabilities, such as specialized education for children with disabilities or medical care specific to the type of disability (see box 6). Persons with disabilities also form civil society organizations known as organizations for persons with disabilities (DPOs), both to advocate for their rights and to provide specific services for their members.

In GCC countries, *awqaf* are increasingly made to provide services for persons with disabilities. For example, the first school for children with autism in Kuwait was established as an initiative of the Kuwait Awqaf Public Foundation, after a needs assessment had revealed that up until that time, children with autism did not receive adequate services.

Refugees within the region are often not entitled to receive public services from the country where they reside. Palestinian refugees usually receive services from United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), but access to services is even more difficult for refugees from other countries, such as Iraq and the Syrian Arab Republic. To complement services provided by UNRWA, several international and national civil society organizations specifically target their service in health care, education and

youth employment to refugees. Similarly, the stateless population in several GCC countries does not have access to public education and is too poor to afford private schools. In some cases these people receive education in schools run by civil society, which are financially supported by the zakat fund in countries like Kuwait. In Sudan, NGOs run schools in camps for internally displaced persons in South Darfur.[51]

Women often have limited access to vocational training provided by the public sector in the Arab region. In some cases, faith-based organizations specifically target women in their vocational training. In addressing this gap, Islamic charity organizations typically direct women's vocational training in line with their ideology; thus it is usually limited activities that are traditionally linked to the role of women, for example sewing and cooking.

4. Civil society is often more flexible in responding to emerging needs

Several examples have shown that civil society is often more flexible in responding to emerging needs, because they can take decisions quicker.

For example, civil society organizations in Lebanon, such as Amel Association, have been able to respond to the needs of Syrian refugees relatively quickly. Amel has established a special fund for them and has been able to provide them with access to health care through its mobile clinics. Refugees would normally not be able to afford the privately dominated health-care system in Lebanon.

Similarly, several faith-based organizations and political parties have sometimes been first responders in times of crises. In the aftermath of the July War of 2006, Hezbollah supplied displaced persons with water, food and shelter, and promised to pay compensation to people whose houses had been destroyed. Hezbollah itself considers its ability to react quickly to emerging problems as its main strength.[52]

After the 1992 earthquake in Cairo, the Muslim Brotherhood quickly provided shelter and food, while the Government's response was less visible. A similar scenario played out in 1994, when the country was hit by serious floods.[53]

During Libya's recent conflict, the Boy Scouts provided desperately needed basic social services in the city of Benghazi, including everything from cleaning the streets to medical assistance such as first aid and assisting doctors.[54]

5. Many civil society organizations have strong organizational capacity

Many civil society organizations, especially faith-based organizations, have strong organizational capacity. This is reflected in their ability to respond quickly to emerging needs, but also in the structured approach that zakat funds and other charity organizations apply to verify the eligibility of their beneficiaries.

Organizational capacity stems from several factors. Many civil society organizations can benefit from a large network of volunteers contributing to the organization. The Zakat Chamber in the Sudan has some paid employees, but it also has many volunteers who carry out part of zakat collection and distribution.[55] These volunteers have a large network of contacts that give them access to both zakat contributors and potential beneficiaries. Their networks facilitate the verification of potential beneficiaries. Similarly, large grass-roots networks in the community, in which women play an important role, allow Hezbollah to locate potential beneficiaries and react quickly to their needs.[56]

It is also known that Muslim Brotherhood activists are well organized, including professional syndicates of doctors, lawyers and engineers.

Experience gained in professional syndicates helped to build the organizational and administrative skills of a new generation of activists. The response of the Muslim brotherhood in the aftermath the 1992 earthquake, which included health care but also emergency rescue operations, exemplifies their organizational strength and capacity.[57]

Some would also emphasize well-trained leadership as a factor strengthening the organizational capacity of many organizations. For example, the directors of organizations affiliated with Hezbollah rotate on a regular basis, which contributes to building their managerial capacity.[58]

C. Critical issues in civil society involvement in the provision of social services

In spite of all these strengths, the provision of social services by civil society also bears certain risks, which can be observed through several examples in the region.

1. Concentration of services on certain recipient groups and/or in certain sectors

A large number of services mainly address the needs of the middle class. This can be attributed to two interrelated causes. First, members of the middle class are able to help themselves: they can form kinship associations with membership fees and they can afford moderate fees for social services. Second, many organizations would not be able to provide services without taking fees. A certain number of fee-paying beneficiaries are needed to cross-subsidize low income users. Targeting services to the needs of middle income groups is thus a necessity if the provision of social services is to be sustainable. Moreover, many organizations perceive that serving the middle class is not a contradiction of their charitable goals, as they define their activities according to "needs" in society. As long as basic requirements such as health care and education are not widely available in acceptable quality, the wider public, including the middle class, is "in need" of these services.[59]

Many civil society organizations, especially faith-based organizations, also seem to target population groups which are already receiving public social assistance. Many of them dedicate the majority of their funds to orphans, while low income families or other groups are not typically targeted. For example, according to research on zakat in Palestine, support for orphans made up 40 per cent of disbursements in 2011. This is not entirely financed by zakat receipts, but mostly through specific donor funds for orphans. In Jordan, cash transfers to other recipients made up 22.1 per cent of all disbursements, and in Palestine it made up 7.4 per cent.[60] By contrast, the Zakat Fund in the Sudan practices more income targeting than categorical targeting. Little information has been available if and how charitable organizations conduct a needs assessment before deciding on the targeting.

The traditional waqf system leaves the determination of purpose and beneficiaries to the prerogative of the founder, which can also lead to a concentration of services in certain sectors. Currently, *awqaf* are mainly made for purely religious purposes such as to build and maintain mosques. Even in history, a certain concentration of *awqaf* in some sectors was observed. For example in certain times during the Ottoman Empire, there was an oversupply of soup kitchens which were all founded through *awqaf*. However, several countries in the region such as Kuwait, Qatar and the United Arab Emirates are already seeking to improve allocation of *awqaf* across sectors and seek to encourage *awqaf* into social sectors (box 7).

2. Fragmentation and duplication of services

Lack of coordination between civil society organizations may often lead to fragmentation and duplication of services. In one case in

Box 7. Directing *awqaf* into social sectors

Kuwait has established a mechanism to harness the potential of *awqaf* for the provision of social services and direct *awqaf* into social sectors according to community needs.

Before oil was discovered in Kuwait in the 1960s, social services were largely provided through *awqaf*. Thereafter, the State started to provide services. Yet, as the practice of waqf was deeply embedded in culture and religion, *awqaf* continued to be made but were mainly used to establish mosques, as was customary in Kuwait and in poorer countries in Africa and Asia.

Realizing the potential of *awqaf* for the provision of social services, the Government of Kuwait sought to revive this potential. To this end, the Government established the Kuwait Awqaf Public Foundation in 1993, as an independent authority to administer and invest *awqaf*. Another purpose of the foundation is to actively identify projects that can attract funding through *awqaf*. The foundation now controls an estimated 80 per cent of all Sunni *awqaf* in the country, but only a small number of Shia *awqaf*.

By establishing project funds covering different sectors, *awqaf* has transformed from a supply-driven to a demand-driven system. The foundation undertakes studies on societal needs and establishes projects on that basis. Founders can give *awqaf* to these projects, and the rule that the founder alone determines the purpose and beneficiaries of the waqf is still preserved. A notable project established by the foundation is a learning institution for children with autism, which is the first of its kind in Kuwait. The project was launched after assessing the needs and gaps in service provision in the country. It also conducts media campaigns to educate the wider public on the possibility and the need make contributions for social sectors.

Due to the efforts of the foundation, awareness of the potential of *awqaf* for social development has increased. In 2013, an estimated 65 per cent of *awqaf* administered by the foundation targeted mosques, and the rest targeted social sectors.

Source: Kuwait Awqaf Public Foundation.

Palestine, two different NGOs opened policlinics in the same small village. There is a need for greater cooperation between secular and faith-based organizations even though they may have conflicting goals or perspectives on how social services should be provided and how to best serve beneficiaries. Cooperation between faith-based organizations, even those of the same faith, is also often deficient. Faith-based organizations sometimes compete with each other in their social and political goals or their specific interpretation of the faith.[61]

In Jordan there are several systems of cash transfers: from the National Aid Fund (NAF), the Zakat Fund, and from various Islamic charitable associations. Although all these funds generally check if applicants already receive funds from other providers, this practice leads to a fragmented system of cash transfers, each of them being too small to lift recipients out of poverty, even when a family receives transfers from several organizations. Moreover, application and verification procedures are time-consuming for both sides. Organizations are often aware of this situation, but due to the large demand for social assistance they feel that it is difficult to increase the amounts given as cash transfers. Instead, organizations opt to be extremely selective in choosing their beneficiaries.[62]

There are also a large number of civil society organizations facilitating health-care services free of charge for low income groups. In some cases, health-care service providers charge according to the patient's ability to pay and cover the remaining cost through zakat and other donations. There are also several organizations that finance health care for low-income groups. The services are provided by public and private practitioners. Low income groups face a fragmented system of providers of health-care finance and often have to secure financing first before being able to access service.

Similarly, organizations providing services for persons with disabilities are often fragmented. Many civil society organizations target their services towards specific types of disability and the medical needs related to it. However, this fragmentation renders the actions of every organization small in scale without being able to make significant changes, and can make it difficult for persons with disabilities and their families to find the organization that provides services for their needs.

3. Approaches of civil society organizations range from charitable, to paternalistic to rights-based

Civil society organizations come from a variety of backgrounds with a diversity of goals, which affects their approach and relationship to beneficiaries. Approaches can also vary among faith-based organizations of the same faith, which not only reflects different philosophies but also different learning stages.

Approaches of charitable organizations to their beneficiaries may vary. Some charity organizations appear to take a rather paternalistic approach. Volunteers serving in these organizations are usually middle class and seem to doubt the capability of members of the lower class to judge what is best for themselves. Charities may fail to consult beneficiaries on what they need to improve their situation. Instead, they emphasize the need to participate in courses designed and provided by the charity.[63]

Many faith-based organizations particularly target and support orphans, who are defined as children whose father has died. Women are not considered as breadwinners, even if they have an income.[64] This raises two critical points. First, it is not always the case that women are unable to create sufficient income. Second, through this approach, the mothers, who usually have to pick up aid from the organization, are not seen as the bearers of rights, but treated as a caretaker of the bearer of rights, the orphan.

There are also some concerns about gender equality in the approach of several organizations. Leadership of Islamic faith-based organizations as well as of kinship associations is mainly male. The Zakat Committees in Palestine are mostly headed by men, although women are not expressly prohibited from that role. The distribution of cash transfers under the umbrella of the Islamic Charity Center Society in Jordan is also usually done by men, although women are usually those to receive aid. Concerning gender relationships in faith-based charity organizations, "the male workers often play the role of the hard taskmaster, enforcing discipline and turning away people who, according to the rules of the association, are ineligible to receive aid. Relations between male workers and female clients in general are characterized by hierarchical distance and a more impersonal attitude."[65] Men are the main beneficiaries of some of the services, especially job contacts, provided by kinship associations.[66]

Research on faith-based organizations providing services in a large informal settlement in Cairo also revealed that users felt humiliated by the modalities for cash hand-outs. Aid recipients usually have to line up at the organization's premises to receive aid, which

is only given to those who attend religious instruction. Recipients indicate that they only accept these conditionalities because they did not have access to other social protection measures.[67] But it seems that this is not the case for all faith-based organizations. A survey conducted by Birzeit Univesity in 2004 revealed that Zakat Committees in Palestine enjoy a high level of public trust, more so than civil societies and charities, labour unions, and political parties.[68]

To sum up, different civil society organizations adopt a range of approaches towards their beneficiaries. However, relatively little is known about the extent to which civil society organizations as a whole, whether secular or faith-based, conform to a rights-based approach. Some examples also show that civil society organizations developed in a learning process, evolving from a charitable or even paternalistic approach to an approach that aims to empower people.

4. Risk of deepening sectarian lines or organizations taking undue influence

When faith-based organizations play a large role in the provision of social services, there is the risk of reinforcing sectarian divides. In Lebanon's education sector, the majority of schools are run by various religious congregations or political parties. Regulations are relatively weak, which allows special interest groups to influence policies. Thus, curricula are largely determined by religious congregations and their leaders.[69] Due to this influence, schools within a single country often even teach different versions of history.

In Lebanon, patterns of access to health services also follow sectarian lines. Although most groups assert that health-care services provided by their group are open to the wider public, the distribution suggests that their main beneficiaries are among their own sect. In addition, many hospitals run by faith-based organizations or political parties provide preferential treatment to those of their own sect. Access to discounted treatment is typically dependent on political affiliation. In Lebanon, many civil society organizations with sectarian or political affiliation consider it as natural that they have to serve the members of their own group first. Hezbollah's health-care services can be found in Beirut's southern suburbs where the party has a stronghold.

The provision of essential services such as health care can contribute to strengthening people's alliance to a certain group. For example, public support to the Muslim Brotherhood or Hezbollah is often linked to their ability to provide widely affordable social services of good quality.

Several faith-based organizations also provide religious education, which they link to their charitable activities. For example, charities under the umbrella of the Islamic Charity Center Society in Jordan expect that educational activities will improve the lives of the target group. The content of the courses that they provide is largely driven by what they perceive to be the main ills of society, such as moral decay and a lack of religious consciousness.[70] Some faith-based organizations operating in informal settlements in Cairo provide cash transfers only to those who fulfil certain conditionalities, such as attending religious classes. Some also link targeting to compliance with certain rules, such as the dress code. Propagation of the organization's interpretation of the faith is a core element of their work.[71]

5. Accountability mechanisms of civil society organizations still need development

Many organizations do not have complaint mechanisms in place. But there are some exceptions. For example the Social Welfare Fund in Yemen, which receives zakat funds, has

established a complaint mechanism. Yet, many beneficiaries do not know about this mechanism, and thus they do not use it.[72]

Overall it is unclear to whom civil society organizations should be accountable, and how they should be monitored for compliance, especially as there is no obligation that civil society organizations must serve the wider public.

Several organizations seek to improve their accountability standards. Although several Islamic charity organizations, including zakat funds, publish annual reports, these reports do not enable detailed analysis of the sources of funding and the beneficiaries. For example the Zakat Funds of Kuwait and the Sudan only mention how many families received cash-transfers without describing the characteristics of these families. Similarly, the Kuwait Awqaf Public Foundation provides detailed data on *awqaf* in the country and their use for different categories. The Zakat Funds of Kuwait and the Sudan are also audited by an independent auditor.

By contrast, in Yemen, zakat funds are merged with the budget at governorate and at district levels, as well as with the overall budget of the Social Welfare Fund, and so it is difficult to gather information on the distribution of those funds.[73] Likewise, it is virtually impossible to gather information on the financial sources and spending of many faith-based organizations in Egypt.[74]

Also, it should also be noted that the administrative costs of some zakat funds are relatively high, which may imply that they are less effective as service providers and may reduce their credibility with the public. Employees of the zakat funds, who are, according to the Koran, also entitled to receive zakat, received 27 per cent of zakat in Palestine in 2011 and 14 per cent in the Sudan, although zakat collection is mainly done by volunteers.[75]

D. Regulation of social service provision by civil society

Non-state actors that provide social services, whether they are civil society organizations or private sector businesses, are usually subject to regulations by the responsible ministries. For example, for-profit schools and those maintained by civil society are subject to the same regulations by the Ministry of Education. In most cases, the same applies to civil society provision in the health-care sector.

However, civil society organizations in most countries have to be licensed. Licensing procedures are often complicated, even in countries of the region that enjoy a vibrant civil society, such as Egypt and Jordan.

In Egypt, civil society is governed by the provisions of the Law on Non-Governmental Societies and Organizations (No. 84 of 2002). Licensing is mandatory and civil society organizations can only operate with a permit from the Ministry of Social Affairs or the Ministry of Health. The Ministry of Social Affairs also has the authority to dissolve an organization that is deemed as "threatening national unity" or "violating public order or morals". However, registered NGOs also enjoy certain benefits such as reduction in telephone, water, electricity and gas charges, and an exemption from stamp taxes, customs duties and contract registration fees.

Technically speaking, NGOs in Lebanon are still subject to the Ottoman Law on Associations of 1909. NGOs have to inform the Ministry of Interior of their existence, but no permits or licenses are needed to form the association.[76] Under this law, Hezbollah registers subsidiary organizations as NGOs to facilitate cooperation with other organizations.[77]

Palestine adopted in 2000 the Law on Charitable Associations and Community Organizations

(No. 1/2000), which is considered the most liberal NGO law in the region. Although licensing is required with the Ministry of Interior, the process is relatively easy. Moreover, the Ministry of Interior does not have the right to reject associations on grounds as being against "public morals" or "national interest".[78]

In GCC countries, the number of NGOs is relatively limited, most of them being initiated by Governments or private foundations or by members of the royal families. Such organizations are sometimes referred to as "parallel organizations" or government-organized NGOs.[79] They provide social services in other countries where civil society participation has been restricted, such as in the Syrian Arab Republic.

Regulation of zakat funds varies in every country, depending how the fund is set up. As outlined earlier, it can be a governmental organization, an independent civil society organization or a government-organized NGO. The zakat system in Palestine is set up in between the spheres of Government and civil society and is subject to certain regulatory peculiarities. While zakat committees can be considered as grass-roots organizations, the zakat fund that supervises them is a government-organized NGO. The zakat committees are supervised by the Ministry of Awqaf, not the Ministry of Social Affairs, as is the case for other welfare NGOs.[80]

Some countries lack a particular regulatory environment for non-profit organizations. For example, some private foundations in Lebanon consider it as a challenge for the effectiveness of their services that there are no particular tax incentives for them and they cannot apply for government funding.[81]

Awqaf are vital in GCC countries, which have a legal environment to regulate those endowments. However, in other countries, there is currently no adequate legal framework for *awqaf* in the provision of social services. For example in Egypt, all private *awqaf* were nationalized in 1954 and placed under the Ministry of Awqaf, which was created for that purpose. The current legislative environment does not encourage *awqaf* to support social services, thus, most organizations based on an original waqf are registered as charitable associations.

E. Summary

The contribution of civil society to the welfare mix is generally difficult to measure because of limited data availability. However, available data and information shows that the contribution of civil society varies from country to country in the region, with the largest contributions in Lebanon and Palestine. In Lebanon, education is dominated by civil society, mainly Christian churches and Christian charities, and Muslim organizations. While the contribution of Christian churches has a longer history, the number and importance of Muslim civil society organizations increased over the course of the twentieth century. In Palestine, civil society was brought in with encouragement from foreign donors after the Oslo II Accords, as it was clear that the Palestinian Authority would have a limited capacity to provide social services.

In Egypt and Jordan, the role of civil society increased in the second half of the twentieth century, largely in line with cuts in social spending. Faith-based organizations in particular proved their capacity to provide a good quality of social services, including health care and education, at lower prices than the private sector. Religious organizations also have the financial and organizational capacity to coordinate cash hand-outs. In some cases, these hand-outs are conditional, for example subject to attendance of religious instructions or adhering to a certain dress code.

In GCC countries, private foundations and Islamic Charitable Organizations based on *awqaf*

play a large role in the provision of social services within GCC countries, and sometimes provide support to other countries both within and beyond the Arab region. Through *awqaf* and generally as a result of the wealth in these countries, they are able to mobilize large financial resources, which are used primarily to build mosques, but also for social services such as health care, education, housing, and water and sanitation. There are also efforts to harness the potential of *awqaf* to an increasing extent for the provision of social services. Several countries have established a centralized authority to encourage *awqaf* to support priority sectors.

This chapter has shown that civil society has the capacity to mobilize resources and organizational capacity in a way that the public sector is not always able to do, especially in view of budgetary constraints and the call to reduce public sector employment. Unlike the public sector, civil society is usually able to draw on a pool of staff working on a voluntary basis.

Given the charitable goals of many civil society organizations, especially faith-based organizations, it should be expected that they mainly target poorer population groups. However, in reality, many civil society organisations target the middle class, to cross-subsidize the poor: good quality services, especially in health care, mainly target the middle class and charge fees for services. Cross-subsidization and charitable contributions also allow for the treatment of a limited number of low-income patients. In addition, the charitable arms of these organizations provide health-care financing for low-income groups.

Widespread categorical targeting among faith-based organizations, for example targeting orphans, results in concentration among these groups and many families with income poverty remain underserved. Zakat funds and Islamic charitable societies, including *awqaf*, tend to concentrate their activities on families without a male breadwinner. From the perspective of a rights-based approach, this raises the concern that although it actually targets female heads of households, the mother is not the bearer of the entitlement. This approach may perpetuate dependency.

Traditional instruments of social protection such as zakat and *awqaf* also bear potential for income redistribution. *Awqaf* are typically made by the wealthy and are supposed to serve the community. Zakat is intended to redistribute wealth through taxation. In reality, however, these distributional effects do not always materialize, as some wealthy income groups tend to evade payments.

Because civil society is not uniform, but consists of a large variety of faith-based and secular organizations, sometimes with competing goals, it is not surprising that civil society organizations rarely coordinate their activities. Thus, there can be some duplication of the services provided by civil society, but also duplication of public sector services.

In some cases, civil society services are tied to political patronage and aim to strengthen an organization's influence in society. A high level of civil society involvement in the provision of social services can increase political patronage and deepen sectarian divides. In some cases there is also concern about outside influence.

The discussion above has shown that civil society can make important contributions to the provision of social services, but if the state relies heavily on civil society to provide social services it risks the deepening of sectarian divides and fragmentation. Over the long term, it can also undermine state capacity, because the state may withdraw from service provision if civil society organizations take over the role of key provider. The main difficulty with the provision of social services by civil society is that it is difficult to

regulate and thus difficult to ensure equity of access and coverage and sustainability. In contrast to the state, civil society cannot be held accountable for providing equitable access to services.

Patterns of civil society provision of social services also show that a group of insiders is relatively well served, while there are still large groups who remain outside the system. The middle class tends to be relatively well served because they can afford to pay on a fee-for-service basis or, alternatively, they can help themselves by forming mutual aid organizations. Lower income groups depend on faith-based or secular charity organizations to gain access to services, however, faith-based organizations in particular may base access to services on criteria that are open to discretion, such as moral codes of conduct.

This underscores the need for integrated social policies that allocate a specific role to civil society and harness its strengths while leaving regulation and basic provision in the hands of the state. One possibility could be to use civil society as a strategic partner. In some cases it could serve as the implementing agency for government policies. Success would depend on the capacity of the state to regulate quality and promote equity in access to services. Another possibility could be to work with civil society to transition from categorical targeting to targeting economic risk. In order to meet the zakat goal of income redistribution and poverty reduction, adaptations in the targeting of beneficiaries may be advisable. There could also be a system to encourage civil society to serve population groups and social sectors that are underserved in the prevailing welfare mix.

Some strategic partnerships between state and civil society already exist for the provision of social services. These include the following:

- The Palestinian Authority purchases services from hospitals maintained by Palestinian Zakat Committees;
- The Government of Egypt funds the system of Al Azhar schools, which runs parallel to the public school system, using the curriculum by the Ministry of Education, but with more emphasis on religion;
- The Government of Lebanon subsidizes schools maintained by civil society, although with relatively limited control on curricula and teaching methods. The Lebanese Government funds several hospitals and clinics that are managed by civil society; in some cases, civil society organizations have taken over the management of government hospitals;
- The Government of Kuwait systematically makes use of *awqaf* for the provision of social services.

In order to design policies that involve civil society in the provision of social services, it would be important to conduct more detailed research on this issue, and in particular to generate more knowledge on the beneficiary groups of services provided by civil society.

Chapter V

V. TOWARDS A NEW WELFARE MIX?

Increasing strain on the formal labour markets and rising unemployment, especially among youth, have deepened the welfare dualism in Arab countries. Employment-based social protection systems are becoming increasingly incapable of integrating more and better-educated youth. On average, no more than one third of workers are contributing to pension schemes, and a similar share is covered by social health insurance.

Governments strive to compensate for these deficits by providing cash transfers and other income support. However, highly fragmented and insufficiently endowed social assistance schemes are not able to cover all individuals and households in need. An estimated 70 per cent of the poorest households do not receive income support from the Government.

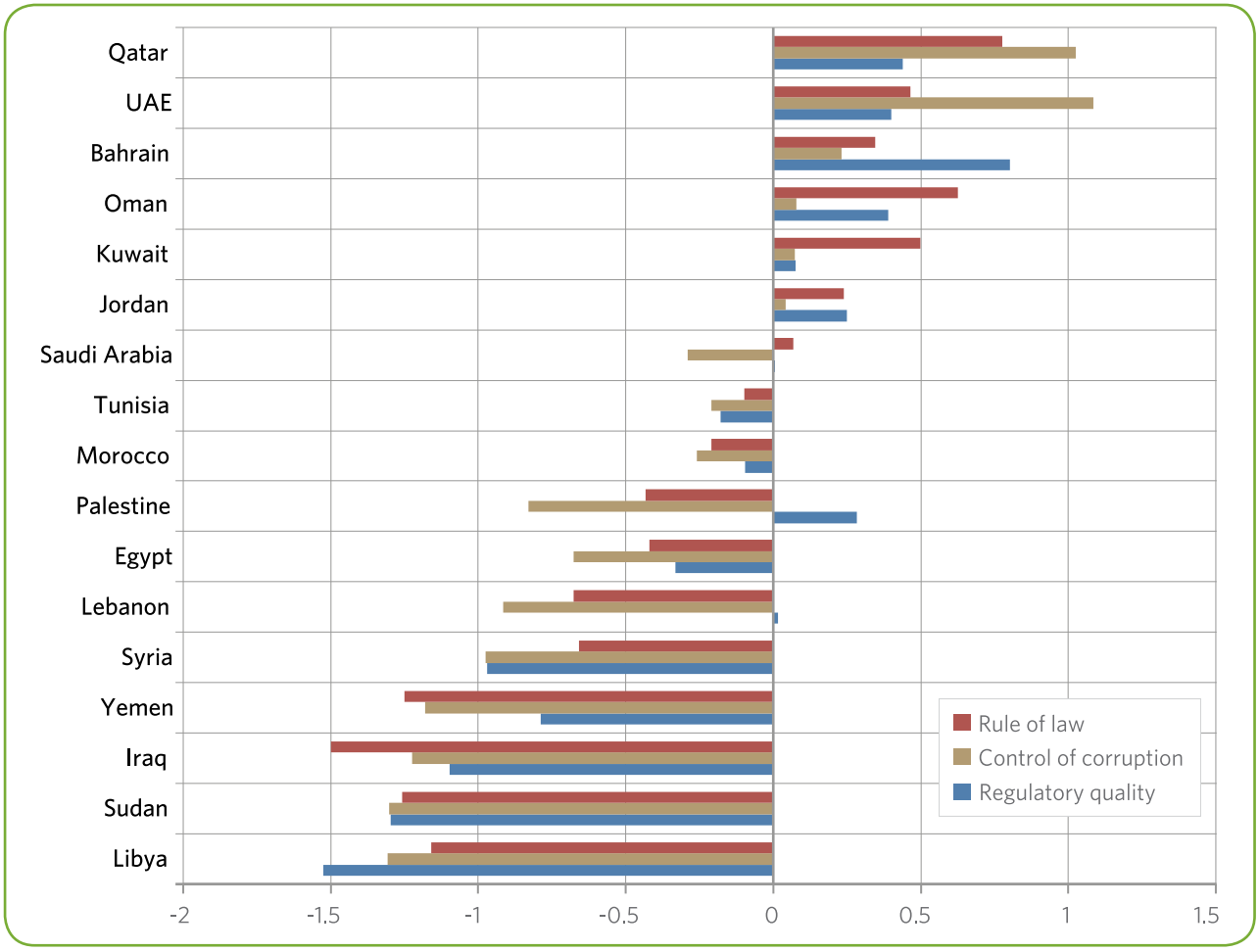
In addition, public social services are increasingly unable to satisfy the needs of the population for education and health-care services. Insufficient coverage, especially in rural areas and poor informal settlements in urban areas, and the inadequate quality of services are evidenced by highly unequal health and education outcomes.

The many disadvantages of the informal sector, including precarious work conditions, low wages, insufficient income support and insufficient access to good quality education and health-care services leave societies divided, not only in terms of income distribution but also in terms of their human capital. Such welfare dualism is not sustainable and makes societies highly vulnerable with regards to social cohesion and economic and social development.

The quantity and quality gaps left behind by the public sector encouraged private sector and civil society interventions, leading to the privatization of social services that was strategic in some cases but rather spontaneous in others.

In GCC countries, the role of the State has begun to shift from a provider to a regulator of services. Free public services are increasingly confined to the national population while the private sector has been brought in systematically to serve foreign residents. In addition, the private sector is encouraged to provide complementary services to the national population, while the Government maintains regulation over quality and costs of services. It appears that for their nationals, GCC countries follow the model of the social protection floor, where a certain minimum of social protection and free public services are provided, which can be complemented by more elaborate services from the private sector. For expatriates, the social protection floor is turned upside down: high-income expatriates have good access and are covered by private insurers, while low-income expatriates often face difficulties accessing health-care services.

Figure 15. Selected governance indicators for selected Arab countries, 2011



Note: These indicators are an aggregate index based on perceptions on a scale from -2 (lowest) to +2 (highest) Regulatory quality captures perceptions of the ability of the government to formulate and implement sound policies and regulations that permit and promote private sector development. Control of corruption captures perceptions of the extent to which public power is exercised for private gain, including both petty and grand forms of corruption, as well as "capture" of the state by elites and private interests. Rule of law captures perceptions of the extent to which agents have confidence in and abide by the rules of society, and in particular the quality of contract enforcement, property rights, the police, and the courts, as well as the likelihood of crime and violence.
Source: World Bank, Worldwide Governance Indicators database.

In other countries, commercial as well as civil society providers have responded more spontaneously to emerging gaps and needs. While private enterprises typically provide higher quality education and health-care services for those who are able to pay, they may also turn out to be providers of last resort, for example in conflict situations where the state and other actors are incapacitated, as was the case in Lebanon.

In countries like Egypt, Lebanon and Palestine, but also in countries like Jordan and Kuwait, faith-based organizations are essential to compensate for gaps in quantity and quality. Apart from providing education and health-care services to middle-income groups, faith-based organizations also distribute assistance to poor and vulnerable parts of the population, mainly through the zakat funds and similar institutions. Their support

to the population is vital and should not be underestimated.

Nevertheless, the multitude of different organizations and their practices of targeting certain groups may also replicate the problems found in the public sector. A high level of fragmentation leaves individual organizations underfunded, and targeting social groups such as orphans focuses on the same categories also targeted by the public sector. Thus, the organizations may not succeed in closing the gaps, and social problems such as income poverty and the working poor may remain unaddressed. Many civil society organizations possess a high degree of organizational capacity and tight networks that help them to determine the eligibility of recipients. But their procedures are sometimes perceived as humiliating, and aid is sometimes subject to conditionality. Overall, it is not clear to what extent these organizations follow the logic of a rights-based approach.

Furthermore, it is interesting to note that although receiving zakat is regarded as a right and an entitlement of the poor under a traditional value system, this does not necessarily translate into a legal right that could result in enforceable claims on the state, which would correspond to a rights-based approach. Thus, services provided by faith-based or other civil society organizations cannot be regarded as part of an effective social protection system or efficient welfare mix unless they are provided in coordination and in partnership with the state, which would guarantee their sustainability, quality and sufficiency.

Similarly, the private sector can contribute to a welfare mix through its flexibility, its financial capacity and its ability to identify market niches. In some cases, the private sector can pioneer the provision of social services and trigger government action (as in the case of preschool education) or even social change (such as sports for girls in Saudi schools). Generally, the strength of the private sector lies in providing services at higher levels of the social protection staircase. Through partnerships, the public sector could harness the strengths of the private sector in the welfare mix and ensure equity of access through regulation or government support, where appropriate.

Among other factors, the decision in favour of a certain welfare mix depends on the social structure, cultural preferences, and relations between citizens and the state. In cases where trust in public services has been eroded by high levels of corruption, failing services, and poor work ethics of civil servants and public sector employees, the Government may choose to provide services through partnership with trusted organizations, be they from the private sector or from civil society. At the same time, care must be given to regulate these frontline organizations in a way that they do not deepen existing cleavages in society and further erode social cohesion. The system of service provision by faith-based organizations in Lebanon is a case in point.

It therefore appears that it is not necessarily possible for countries with weak regulatory and public sector capacity to resort to private sector or civil society actors for the provision of social protection. If limited administrative capacity, inadequate targeting and problems of corruption have brought about the failure of public services, the 'outsourcing' of social protection and social services to multiple actors with different aims could exacerbate existing welfare dualism, should the Government prove unable to enforce standards, monitor operations and ensure equality of access.

Sufficient regulatory capacity in Arab countries cannot be taken for granted. According to governance indicators developed by the World Bank, regulatory quality, control of corruption and rule of law range from good capacity in GCC countries to rather low scores in Iraq, Libya, the Sudan and Yemen (figure 15). Poor control of corruption generally weakens a country's capacity

to regulate non-state actors, and corruption undermines service delivery as a whole.

In general, countries where the private sector was brought in by design are those with higher regulatory capacity. Examples include the Council for Cooperative Health Insurance in Saudi Arabia, the National Health Regulatory Authority in Bahrain, the Health Authority of Abu Dhabi and the Dubai Health Authority. The role of private schools in Abu Dhabi, described in chapter III, is another case in point.

Countries where the involvement of non-state actors is more a spontaneous response to gaps and needs tend to also have weaker regulatory capacity. This raises the concern that these countries may be unable to regulate the activities of non-state actors in an equitable way. They may be unable to ensure that the provision of social protection and social services by non-state actors, although urgently needed, will not deepen inequity in access or perpetuate the dichotomy between insiders and outsiders.

Several Governments in the Arab region will thus have to rethink their current welfare mix and how they can fulfil their promises to guarantee the rights of social security, which 12 out of 17 ESCWA member countries agreed to provide when they signed the International Covenant on Economic, Social, and Cultural Rights.[1] The United Nations System recommends the social protection floor as a suitable approach to start mastering the challenges of social protection in developing countries, as it aims to integrate those who currently are not covered by existing social security systems, and to strengthen coverage where it is insufficient.

A. The way forward

In order to move towards improving social protection and social services, Governments may wish to consider a more active role in shaping their specific welfare mix and to clarify their own roles as the ultimate guarantors of the social rights of their citizens.

1. Establish clear policy priorities towards improving basic protection and services

Governments at present are often rather thinly stretched, assuming multiple roles as the guarantor, the regulator and the provider of social protection and social services. Against the background of limited capacity, it may be advisable to establish clear policy priorities and clarify the role of the public sector in the welfare mix.

In this regard, Governments may consider focusing on basic services, which should be provided across geographical regions and social groups in good quality, as suggested by the concept of the social protection floor. A clear focus on primary health-care centres with clear quality standards and on free and high-quality primary and secondary education would offer equal opportunities to citizens independent of their social background and assist people in their human capital formation. The quality of these basic services should be ensured through results-oriented management with clear accountability standards and monitoring.

When the public sector concentrates on providing basic health-care services, the state can improve access to more elaborate services by purchasing them from non-state actors, such as the private sector or civil society, as is already being done in Jordan, Palestine and Tunisia.

Moreover, even basic services cannot be provided effectively if they are not equipped with adequate budgets. To this end, Governments may consider establishing a catalogue of basic rights and entitlements and calculating their costs. This should also be the starting point for a national dialogue with all stakeholders, discussing the limits of state provision of social protection and services.

2. Remove fragmentation and duplication in services

In the current welfare mix, public social assistance is largely based on subsidies. Apart from that, low-income groups face a fragmented system of social assistance schemes, consisting of the multiplicity of faith-based and civil society organisations providing limited income support. This situation leads to duplications and inefficiencies in delivery, and creates barriers to accessing these schemes.

In order to improve the overall efficiency of the system as well as broaden access to social assistance, the public sector must streamline social assistance schemes by consolidating the number of programmes, applying coherent criteria for eligibility and establishing systems for data and information sharing. The ability of the state to influence civil society may be limited in some cases, but it is easier in the case of government-organized NGOs, such as the zakat funds in some countries. However, better coordination between civil society and the state is desirable.

Initial steps in this direction have already been taken in Palestine, where the Government has joined with NGOs in a social protection team to address the needs of vulnerable groups, including the elderly, persons with disabilities and women. The vision of the Ministry of Social Affairs is to become the dominant coordinating agency for all social protection efforts by building a formal, institutionalized framework for coordination between different ministries and non-state actors. It is envisioned that all organizations should share basic levels of information, and coordination should be based on a formal system of memorandums of understanding, clearly laying out different roles and responsibilities. Although this initiative is still in a planning stage, it already marks a step forward in addressing fragmentation and duplication.

Removing fragmentation is equally important for the efficient delivery of social services. As discussed in chapter two, health systems would benefit from consolidating and streamlining the delivery infrastructure and financing streams.

3. Improve coverage and expand access to social insurance schemes

One approach to removing fragmentation can be through the extension of social insurance schemes. This requires an expansion of formal work contracts to those currently working informally, so that more workers are covered by contributory pension schemes and social health insurance.

To date, one of the obstacles to the expansion of coverage is that enterprises must make high social security contributions, which increase labour costs and are a burden, especially for smaller enterprises. Governments may wish to consider removing fuel subsidies, which tend to benefit enterprises and less needy parts of the population, and reallocate those funds to subsidize social insurance systems in order to decrease contributions from employers and employees.

In recent years, a different approach has been taken by the Jordanian Social Security Corporation, which launched a national project to extend coverage of social security to more workers as well as the informal sector, housewives, agricultural workers and so on. The project has been implemented in several steps. First, coverage was increased by introducing mandatory coverage for enterprises with one to four workers. This was implemented between 2008 and 2011. In 2010, the legislation was changed to make voluntary payments possible for anyone who wished to be insured, thus providing access to coverage for workers in the informal sector, agricultural workers and the unemployed. In addition, there was an effort to encourage Jordanians abroad to sign

up for a voluntary scheme which had been in place since 2005. Prior to the initiation of the project in November 2008, 53.4 per cent of the employed residents of Jordan were registered. By September 2011, this number had increased to 62.4 per cent.[2]

4. Expand and refine the policy infrastructure to identify people in need and avoid leakage

Targeted social assistance requires a policy infrastructure that extends especially into rural and low-income areas, and the ability to identify those in need and minimize leakage. In this respect, the public sector may learn from civil society organizations. Through broad networks, civil society organizations are able to verify the eligibility of applicants and are able to identify eligible recipients who would not apply for assistance on their own initiative.

There are already some examples of countries improving the policy infrastructure to identify people in need. With its National Poverty Targeting Programme, Lebanon aims to establish a targeting system for all social transfers and services that seek to improve the living standards of the most poor and vulnerable. In centres established throughout the country, households can apply through an automated selection process, to avoid discretionary decisions.[3]

5. Identify strategic partners for the provision of social services

A review of the core strengths and responsibilities of the Government is required, as well as a commitment to organize social policy in a way that facilitates equal access to protection, good quality education and health-care services across rural and urban areas, for all income groups and independent of their ability to pay. Better service delivery also requires expanding the capacity of the state through strong, transparent and reliable partnerships with other actors. There must be sufficient regulatory capacity to identify the strengths and limitations of other actors, to shape regulation accordingly, and to monitor their actions in accordance with clear quality standards.

(a) Private sector

Private sector initiatives are an essential component of the welfare mix. Its capacity for innovation, ability to identify market niches, establish efficient operations and mobilize financial and human capital makes the private sector a strategic partner for Governments. In particular, services that go beyond the coverage of basic needs such as private insurance, tertiary education or advanced medical services are often efficiently delivered by private sector enterprises and institutions. Initiatives of corporate social responsibility often complement government services in critical areas.

Nevertheless, Governments must ensure that private enterprises also take on their fair share of social responsibilities. This means ensuring that private enterprises pay fair wages and offer decent work conditions, but also balance access to private sector services for those with limited ability to pay. Suitable regulation can range from price caps to granting concessions for hospitals only if a viable system of cross-subsidization is in place. Another option could be state subsidies to the private sector, as has been implemented in some Latin American countries for private education.

(b) Civil society

Civil society organizations are ideal partners when flexibility is required to respond to emerging needs, when certain vulnerable groups need to be reached or when additional organizational capacity through existing networks is required to provide services. Through partnerships, the

state can benefit from civil society's existing policy infrastructure, its ability to win the trust of vulnerable groups and its capacity to reach out to remote areas, as discussed in chapter IV. The state may further encourage the provision of social services by providing tax incentives or other incentives to civil society, while regulating their quality.

In its social protection strategy, Palestine is taking a partnership approach, allocating roles to civil society and, to a limited extent, to the private sector.

Care must be taken that the provision of social services by civil society does not deepen existing divides in the country and that standards of human rights are upheld. When cooperating with civil society organizations, Governments must carefully select appropriate partners.

6. Assess regulatory capacity and undertake incremental steps to strengthen it

Previous recommendations have shown that a welfare mix involving several actors requires a strong government role as a regulator and guarantor of rights, ensuring access to quality services for all. Thus a key requirement for the functioning of a welfare mix is a functioning Government. In cases where capacity is low, the state will not be able to sustain or regulate institutional arrangements and accountability mechanisms that should ensure access to quality services.[4]

Prior to entrusting the provision of social services to other actors, Governments would have to carefully assess their regulatory capacity. Regulatory capacity requires a regulatory body, equipped with financing and adequate staff, a sound regulatory and judicial framework and a coherent regulatory system. As pointed out in the report, some countries in the region such as Bahrain and the United Arab Emirates have already established regulatory bodies. However, a lack of administrative capacity can become a trap: countries that face difficulties serving as a provider of social services due to low state capacity are also very likely to face difficulties in regulating other actors. It is therefore important that overall state capacity be developed and consolidated. Building up regulatory capacity is often a long–term process, but some incremental steps can be taken towards this goal. These include establishing a clear rights-based framework to regulate equity of access to social services, combating corruption and ensuring that the skills and pay of administrative staff are adequate.

B. Further research needs

This report has sought to explore the prevailing welfare mix and identify issues emerging from the current situation with regards to a rights-based approach. Further research is recommended in the following areas:

- The contribution of civil society and the private sector to the provision of social services. In particular, more research would be required on the actual beneficiary groups of services provided by the private sector and civil society;
- The different education providers and the quality of services provided by all actors in the welfare mix. Current data on private school enrollments covers all schools that are provided by non-state actors, without distinguishing between private schools run by private companies, non-profit organizations, civil society (including traditional Koranic schools), and others. As the category of private schools covers a broad range of education providers, it is difficult to carry out deeper analysis. In many cases, users prefer either private sector or civil society services to those of the public sector, because they perceive these services to be of better quality. However, little evidence is available to measure the

quality of services by either the public or the private sector. The targeting practice of civil society organizations, and to what extent their services meet the criteria of a rights-based approach, require further research. Further evaluation could also shed light on how the state could intervene to include civil society in a social protection strategy using the rights-based approach;

- The feasibility of tax reforms and establishing systems of vertical income distribution through the tax system;
- The role of foreign donors in the provision of social services, especially through civil society. Donors are influential actors in a number of ESCWA member countries, and their influence and role in a well-organized welfare mix deserves detailed study;
- The prevailing role of the family in social protection, and how this role is changing over time. The family has traditionally been a main pillar of social protection, which is currently undergoing shifts. The impact of those changes should be studied in greater detail.

Annexes

Overview of pension systems in ESCWA member countries								
Country	**Date of first law**	**Dates of the current laws**	**Source of contributions**	**Coverage**	**Pension age**	**Value of pension benefits**	**Maternity benefits**	**Social insurance exclusion and separate schemes**
Bahrain	1976	1976: Social insurance 2006: Unemployment insurance	Employee: Yes Employer: Yes Government: No	All salaried GCC workers and voluntary coverage for specific groups.	60/55 (M/F) with at least 10 years of participation or any age with 20/15 (M/F) years of participation.	Based on average contributory wage during last 2 years and years of contribution. Settlement sum possible dependent on contributions.	-	Household workers, some groups of agricultural workers, casual workers, temporary non-citizen workers, special system for public sector employees.
Egypt[a]	1950: Social assistance	1975: Civil servants and employees; 1976: Employers; 1978: Migrant workers; 1980: Coverage extension	Employee: Yes Employer: Yes Government: Yes, covers deficit	Employed persons (18+), government employees (16+)	60 (M/F) with at least 10 years contribution or any age with at least 20 years of contributions.	Based on reference base earnings and years of contribution. Arduous and dangerous occupations receive increased rates. Early pension can be paid at a reduced benefit Settlement sum possible dependent on contributions.	Up to 3 months at 75% pay	Special scheme for some self-employed, employers, migrant workers, temporary and casual workers in agriculture, artisans, small land and property owners and household workers.

Overview of pension systems in ESCWA member countries (Cont.)								
Country	**Date of first law**	**Dates of the current laws**	**Source of contributions**	**Coverage**	**Pension age**	**Value of pension benefits**	**Maternity benefits**	**Social insurance exclusion and separate schemes**
Iraq	1956: Provident fund	1971	Employee: Yes Employer: Yes Government: Subsidy	Private enterprises with 5 + workers	..	..	..	Agricultural and temporary employees, domestic servants, and family labour. No specific information about coverage for self-employed. Special schemes for public sector, semi-governmental agencies, lawyers, and journalists.
Jordan	1978	2010: Social security legislation	Employee: Yes Employer: Yes Government: Covers deficits	Public and private employees and Jordanian citizens working at diplomatic missions or for international organizations. Voluntary coverage for all residents and citizens abroad.	Old age: 60/55 (M/F) with at least 15 years coverage, including 84 months of paid contributions. Early pension (for those covered before October, 2009): Age 50 with at least 25/22 (M/F) years of contributions.	Based on average contributory wage during last 2 years and years of contribution. Early pension can be paid at a reduced benefit. Settlement sum possible dependent on contributions. Additional dependent's supplement.	Minimum 9 months coverage before childbirth. Benefit is equal to last monthly earnings for up to 10 weeks.	Foreign employees serving in international organizations or foreign missions.

Overview of pension systems in ESCWA member countries (Cont.)								
Country	**Date of first law**	**Dates of the current laws**	**Source of contributions**	**Coverage**	**Pension age**	**Value of pension benefits**	**Maternity benefits**	**Social insurance exclusion and separate schemes**
Kuwait	1977	1977: Civilians 1981: Military 1995: Supplementary	Employee: Yes Employer: Yes Government: No	Civil servants, oil and private sector workers, self-employed, and military personnel. Supplementary system for employees with earnings greater than United States Dollars (US$) 5310 (1,500 Kuwaiti dinars).	Old age: depending of type of work, marriage status and years in service. Minimum age 45, maximum 65.	Based on average contributory wage during last 3 years and years of contribution. Pensions are higher for military personnel.	-	Special scheme for public sector employees.
Lebanon	1963	1963	Employee: No Employer: Yes Government: No	Employees in commerce, industry and agriculture.	Old age: 60 (compulsory at age 64); Any age with at least 20 years of employment or for a woman who marries and leaves employment during the first year of marriage. Reduced benefit: Any age with 5-19 years of employment if the insured leaves employment permanently.	A lump sum is paid based on the final month of earnings or average monthly earnings during the previous year and years of contributions. Early pension can be paid at a reduced benefit based on contributions.	Medical benefits are provided if at least covered for 3 months over the previous 6 months	Temporary agricultural workers; citizens of countries without reciprocal agreements, self-employed persons. Special scheme for public sector employees.

Overview of pension systems in ESCWA member countries (Cont.)								
Country	**Date of first law**	**Dates of the current laws**	**Source of contributions**	**Coverage**	**Pension age**	**Value of pension benefits**	**Maternity benefits**	**Social insurance exclusion and separate schemes**
Libya	1957	1980: Social security 1987: Disabled persons 1998: Social security fund[b]	Employee: Yes Employer: Yes Government: Yes	All persons residing in Libya.	Old age: 65/60 (M/F), age 62 (civil servants), and age 60 (workers in hazardous or unhealthy occupations), with 20 years of contributions. Employment must cease.	Based on average contributory wage during last 3 years and years of contribution, at least 80% of the minimum wage, approx. US$200 (250 Libyan dinars). Additional dependent's supplement.	3 months full pay plus other benefits	Special system for armed forces personnel.
Morocco	1959: Social insurance	1972: Social security 1981: Extension to agricultural and forestry workers 2004: Early retirement	Employee: Yes Employer: Yes Government: No	Salaried workers and apprentices in most occupations and industries.	Old age: 60 (less for miners) Employment must cease. Early pension: 55 with at least 3 240 days of coverage if the employer agrees to pay the National Social Security Fund an amount equivalent to the value of the pension.	Based on average contributory wage during last 8 years and years of contribution. Benefits are paid monthly or quarterly. Benefit adjustment: Benefits are adjusted periodically.	Up to full pay for 14 weeks	Self-employed persons. Special system for civil servants and other categories of employees.

Overview of pension systems in ESCWA member countries (Cont.)								
Country	**Date of first law**	**Dates of the current laws**	**Source of contributions**	**Coverage**	**Pension age**	**Value of pension benefits**	**Maternity benefits**	**Social insurance exclusion and separate schemes**
Oman	1992	1992: Social insurance	Employee: Yes Employer: Yes Government: Yes	Citizens aged 15-59 employed in the private sector under a permanent work contract or working in one of the GCC countries.	Old age: 60/55 (M/F) with at least 180/120 months of paid contributions. Early pension: 45 to 59 with at least 240/180 (M/F) months of paid contributions. End of service benefit if contribution period too short for pension. Additional end of service grant possible.	Based on average contributory wage during last 5 years and years of contribution. The minimum pension is US$390 (150 Omani rials). The maximum pension is 80% of the pensionable salary. Early pension can be paid at a reduced benefit based on contributions. Lump sum possible dependent on contributions.	-	Foreign workers, household workers, artisans, self-employed persons
Palestine[c]	1954	1954:Gaza Civil Servant Pension System 1959: West Bank Civil Servant Pension System 2005: Public Pension Law	Employee: Yes Employer: Yes Government: Yes for public servants and deficits of schemes	Estimated to cover 15 per cent of the workforce[d]	West Bank: 60 with 40 years of contributions. Gaza: 60 with 15 years of contributions. Security Forces: 60 with 15 years of contributions.	..	..	Four different schemes depending on geography and sector. To be consolidated by 2020.

Overview of pension systems in ESCWA member countries (Cont.)								
Country	**Date of first law**	**Dates of the current laws**	**Source of contributions**	**Coverage**	**Pension age**	**Value of pension benefits**	**Maternity benefits**	**Social insurance exclusion and separate schemes**
Qatar	2002: Retirement and pensions	2002 law implemented in 2003 2007: extension of protection to GCC citizens working abroad	Employee: Yes Employer: Yes Government: Yes, administrative cost and deficits	Qatari public-sector employees, some categories of private sector workers, and Qatari citizens working in other GCC countries	Old age: 60/55 (M/F) with 15 years of contributions. Early pension: 40 with 15 years of contributions. Old age settlement: Paid if the insured does not meet the qualifying conditions for an old-age pension.	Old age: Based on gross earnings during last 5 years and years of contribution. Early pension can be paid at a reduced benefit based on contributions. Lump sum possible dependent on contributions.	..	Self-employed persons, household, family, and foreign workers. Special system for military personnel
Saudi Arabia	1969	1969 law implemented in 1973 2001:Social insurance	Employee: Yes Employer: Yes Government: Yes, administrative costs and deficit	Private sector and some categories of public sector Saudi workers. Voluntary coverage for persons who are self-employed, are working abroad, or no longer satisfy the conditions for compulsory coverage.	Old age: 60/55 (M/F) with at least 120 months of paid or credited contributions Shorter contribution period for arduous or dangerous work. Employment must cease. Old age settlement: Paid if the insured does not meet the qualifying conditions for pension.	Old age: Based on average earnings during last 2 years and years of contribution with a maximum. The minimum pension is US$460 (1,725 Saudi Arabian rials) per month. Old age settlement: Lump sum possible dependent on contributions.	-	Agricultural workers, fishers, household workers, family labour, foreign workers. Special system for civil servants and military personnel. No specific information about coverage for self-employed.

Overview of pension systems in ESCWA member countries (Cont.)								
Country	**Date of first law**	**Dates of the current laws**	**Source of contributions**	**Coverage**	**Pension age**	**Value of pension benefits**	**Maternity benefits**	**Social insurance exclusion and separate schemes**
Sudan	1974	1990: Social insurance 2004: Amendment	Employee: Yes Employer: Yes Government: No	Employed and self-employed persons.	Old age: 60 with at least 20 years of contributions. The normal retirement age is reduced for those in arduous work. Employment must cease. Early pension: min age 50 with at least 20 years of contributions. Old age settlement: paid at the normal retirement age if the insured does not qualify for the old-age pension; at any age if the insured resigns or is laid off.	Old age: Based on average earnings during last 3 years and years of contribution with a maximum and minimum. The pension may be partially paid as a lump sum without interest. Early pension can be paid at a reduced benefit based on contributions. Old age settlement: employer and employee contributions are paid; the adjusted current value of contributions is paid if the insured resigns or is laid off.	No statutory cash benefits are provided.	Household workers, family labor, home-based workers, farmers and foresters, unpaid apprentices. Special systems for civil servants and police and armed forces personnel.
Syrian Arab Republic	1959	1976: Amendment 2001: Amendment	Employee: Yes Employer: Yes Government: No	Employees in industry, commerce, and agriculture; civil servants; freelance workers; and employers. Voluntary coverage for	Old age: 60/55 (M/F) with at least 15 years of contributions; 55/50 (M/F) with at least 20 years of contributions; at any age with at least 25 years of contributions.	Old age: Based on base salary and years of contribution. The minimum pension is the legal minimum wage, US$ 54 (6 110 Syrian pounds). Old-age increment: a lump sum	-	Temporary workers, household workers, self-employed persons.

Overview of pension systems in ESCWA member countries (Cont.)								
Country	**Date of first law**	**Dates of the current laws**	**Source of contributions**	**Coverage**	**Pension age**	**Value of pension benefits**	**Maternity benefits**	**Social insurance exclusion and separate schemes**
				Syrians working abroad.	Old-age increment: Insured had at least 30 years of contributions. Old age settlement: 60/55 (M/F) if requirements for the old-age pension not met.	based on years of contributions. Old age settlement: a lump sum of 11% to 15% of total covered earnings.		
Tunisia	1960	1960: Non-agricultural workers, implemented in 1974 1981: Agricultural workers 1985: Civil servants 1989: Improved agricultural scheme 1995: Self-employed persons 2002: Low- income workers 2002: Artists	Employee: Yes Employer: Yes Government: No. The Government subsidizes contribution to enhance economic activity in low-income areas and to encourage the employment of young graduates, persons with disabilities, and other categories of workers.	Private-sector employees from non-agricultural sectors. Voluntary coverage for Tunisian workers employed abroad	Old age: 60/50 with at least 120/180 months of contributions. Employment must cease. Early pension: min age 55 with at least 30 years of contributions. Partial pension: The insured must have 60 to 119 months of contributions. If less than 60 months of contributions, the value of the insured's share of contributions is refunded.	Old age: Based on average earnings during last 10 years and years of contribution. Paid monthly. Minimum and maximum applies. Early pension can be paid at a reduced benefit based on age. A reduced partial pension is paid in proportion to the insured's contributions. If the insured has less than 5 years of contributions at retirement, a lump sum of the value of the insured's contributions is paid.	66.7% of the average daily wage. Average daily wage cannot exceed twice the legal daily minimum wage. The benefit is paid for 30 days and may be extended 15 days	Special systems for civil servants, members of parliament, armed forces personnel, agricultural workers, farmers, self-employed, household workers, artists and certain categories of fishers and low-income earners.

Overview of pension systems in ESCWA member countries (Cont.)								
Country	**Date of first law**	**Dates of the current laws**	**Source of contributions**	**Coverage**	**Pension age**	**Value of pension benefits**	**Maternity benefits**	**Social insurance exclusion and separate schemes**
United Arab Emirates[e]	1971	2000	Employee: Yes Employer: Yes Government: Yes	Nationals working for the Government or in the private sector	..	..	..	No specific information about coverage for self-employed
Yemen	1980	1991:Pensions 2000 and 2008: amendments	Employee: Yes Employer: Yes Government: No	Permanent employees in public sector with special system for military/ police personnel. Private sector employees including Yemenis abroad.	Public sector: Old age: 60/55 (M/F) with at least 15/10 years of contributions; age 50/46 (M/F) with at least 26/20 years of contributions; at any age with at least 30/25 (M/F) years of contributions. Early pension: At any age with at least 25 years of contributions if the insured becomes involuntarily unemployed. Private sector: Old age: 60/55 (M/F) with at least 15 years of contributions.	Old age: Based on gross monthly salary and years of contribution. Paid monthly. Minimum and maximum applies. The minimum monthly pension is US$93 (20,000 Yemeni rials). The maximum monthly pension is 100% of the insured's last gross monthly salary with at least 35 years of contributions; 43% with at least 15 years. Early pensions are calculated in the same way.	..	Casual workers, agricultural workers, household workers seamen and fishermen, self-employed

Notes: Two dots (..) indicate information was not available; A hyphen (-) indicates that the item is not applicable.

a Egypt has approved new social security legislation in 2010 that was supposed to be implemented in 2012; implementation of the new legislation, however, has been delayed due to recent political instability. The old system will continue to exist along with the new one for the next 75 years. Available from http://www.issa.int/News-Events/News2/Reforming-Egypt-s-social-security-system-A-vision-for-social-solidarity/(language)/eng-GB.

b Information dates from 2003. No data is available for the period after the revolution.

c Portland Trust, 2007.

d International Social Security Association, 2013.

e Abu Dhabi eGovernment Gateway, http://www.abudhabi.ae/egovPoolPortal_WAR/appmanager/ADeGP/Citizen?_nfpb=true&_pageLabel=p20166&lang=en.

Source: Compiled by ESCWA based on International Social Security Association, Social Security Country Profiles, 2013, http://www.issa.int/Observatory/Social-Security-Databases and the United States Social Security Administration, http://www.ssa.gov/policy/docs/progdesc/ssptw/2012-2013/asia/index.html.

ANNEX II

Coverage rates of pension, unemployment benefits and employment injury in selected ESCWA member countries						
Country	Share of population above legal retirement age in receipt of pension	Year	Percentage of unemployed receiving unemployment benefits (contributory and non-contributory schemes combined)	Year	Employment injury: Active contributors/ protected persons as a percentage of working age population	Year
Bahrain	36.5	2006	34.2	2008	..	..
Egypt	..	-	..	-	..	..
Iraq	79.5	2004	0	-	..	..
Jordan	42.9	2008	..	-	17.3	2007
Kuwait	43.1	2006	0	-	..	..
Lebanon	23.1	2003	0	-	..	..
Libya	..	-	0	-	..	..
Morocco	16.0	2003	0	-	..	..
Oman	3.5	2008	0	-	8.3	2007
Palestine	..	..	0	-	..	..
Saudi Arabia	..	-	0	-	..	..
Syrian Arab Republic	30.5	2005	0	-	13.3	2007
Sudan	3.8	2005	0	-	..	..
Tunisia	55.1	2006	3	2008	18.7	2005
Yemen	19.2	2004	0	-	4.4	2006

Note: Two dots (..) indicate that data are not available; A hyphen (-) indicates that the item is not applicable.
Source: International Labour Office, 2010, pp. 240-253.

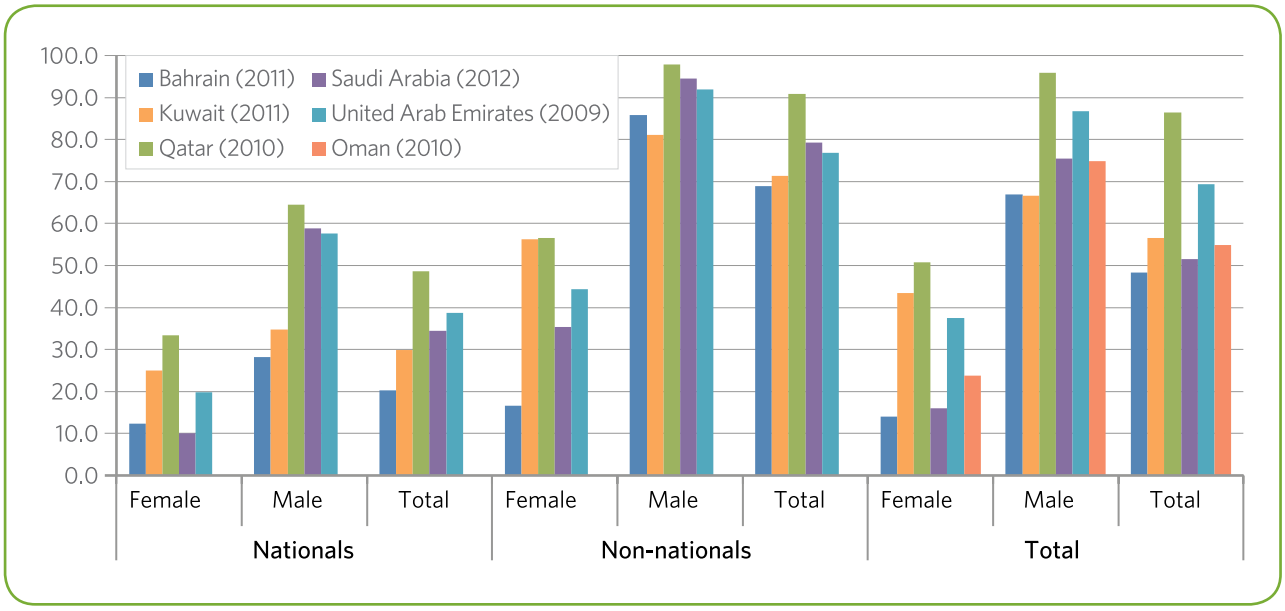
ANNEX III

Labour force participation rate in GCC countries by nationality, most recent data							
Country	Male national	Male non-national	Female national	Female non-national	Total national	Total non-national	Total
Bahrain (2010)	63.2	99.6	32.3	63.4	47.8	90.4	72.0
Kuwait (2011)	37.0	83.0	27.4	58.5	32.1	73.4	58.7
Oman	..	..	..	..	..	..	..
Saudi Arabia (2012)	62.6	94.5	15.7	35.4	39.1	79.4	54.1
United Arab Emirates (2009)	62.5	93.7	27.5	47.7	45.1	79	72.4
Qatar (2012)	68.1	97.7	34.6	58.4	51.3	90.7	86.5

Note: Two dots (..) indicate that data are not available.
Source: **United Arab Emirates**: http://www.uaestatistics.gov.ae/ReportDetailsEnglish/tabid/121/Default.aspx?ItemId=1850&PTID=104&MenuId=1; **Qatar**: http://www.qsa.gov.qa/eng/GeneralStatistics.htm; and ESCWA calculations based on the following sources: **Bahrain**: http://www.cio.gov.bh/cio_eng/SubDetailed.aspx?subcatid=563; **Kuwait**: http://www.csb.gov.kw/Socan_Statistic_EN.aspx?ID=18; **Saudi Arabia**: Central Department of Statistics and Information, 2012.

ANNEX IV

Employment rates, GCC countries, most recent data *(Percentage)*



Sources: ESCWA calculations based on the following sources: **Bahrain**: http://www.cio.gov.bh/CIO_ENG/SubDetailed.aspx?subcatid=568; **Kuwait**: http://www.csb.gov.kw/Socan_Statistic_EN.aspx?ID=18; **Qatar:** Statistics Authority, 2010; **Saudi Arabia**: Central Department of Statistics and Information, 2012; ESCWA, 2011; and www.laborsta.ilo.org.

ANNEX V

Percentage of tax revenue by source *(Latest available year)*				
	Taxes on income, profits and capital gains	Taxes on goods and services	Taxes on international trade	Other taxes
Bahrain (2007)	11.1	3.3	85.6	0.0
Egypt (2011)	46.6	39.6	7.2	6.5
Iraq (2006)	59.4	40.6	0.0	0.0
Jordan (2011)	21.8	66.4	9.4	2.4
Kuwait (2011)	0.0	25.3	65.6	9.1
Lebanon (2011)	23.5	53.4	7.5	15.5
Libya (2008)	79.0	-	14.1	6.8
Morocco (2011)	35.8	49.8	7.1	7.2
Oman (2012)	47.8	0.0	30.0	22.3
Palestine (2008)	6.2	62.4	31.2	0.2
Qatar (2010)	94.0	0.0	6.0	0.0
Saudi Arabia (2011)	20.9	-	38.1	41.0
Sudan (2010)	11.4	51.7	28.8	8.1
Syrian Arab Republic (2009)	52.5	-	10.7	36.7
Tunisia (2011)	43.4	42.6	7.9	6.1
United Arab Emirates (2007)	-	-	58.0	42.0
Yemen (2011)	52.3	33.1	14.6	0.0

Note: A hyphen (-) indicates that the item is not applicable.
Sources: **Bahrain, Egypt, Jordan, Kuwait, Lebanon, Morocco, Oman, Palestine, Qatar and Tunisia**: http://databank.worldbank.org/data/views/variableSelection/selectvariables.aspx?source=world-development-indicators#c_b; **Iraq**: http://www.cbi.iq/documents/Annual_2006f.pdf; Libya: IMF, 2009; **Saudi Arabia**: IMF 2011a; **Sudan**: http://www.cbos.gov.sd/sites/default/files/annual_e_10.pdf; **Syrian Arab Republic**: http://www.banquecentrale.gov.sy/main-eg.htm; **United Arab Emirates**: http://www.centralbank.ae/en/pdf/ebulletin/ebulletin2008-E.pdf; **Yemen**: http://cso-yemen.org/content.php?lng=english&id=598

ANNEX VI

Public expenditure
(Percentage of GDP)

	Public sector salaries[a]	Public pension[b]	Subsidies and other transfers			Social transfers				Health, 2011[a]		Public Education[a]	Public social security[c]
			Total[a]	Consumption goods[d]		Social assistance	Family allowance[e]	Disability	Old age	Total	Public		
				Fuel	Food and ration cards								
Bahrain	10.2 (2007)	0.9 (2004)	1.9 (2007)	2.3 (2010/2011)	0.7 (2010/2011)	..	0.0	0.1	0.8	3.8	2.7	2.9 (2008)	1.3 (2005)
Egypt	7.1 (2011)	3.0 (2010)	12.2 (2011)	6.0 (2009)	2.0 (2009)	..	..	..	..	4.9	2.0	3.8 (2008)	11.5 (2007)
Iraq	..	3.9 (2009)	..	1.5 (2009)	5.4 (2009)	..	..	..	..	8.3	6.7	..	..
Jordan	14.0 (2011)	2.0 (2005)	11.0 (2011)	2.5 (2011)	1.0 (2011)	..	0.0	0.3	1.6	8.4	5.7	..	8.4 (2006)
Kuwait	7.8 (2011)	2.7 (2007)	7.8 (2011)	5.7 (2010)	0.1 (2010)	..	0.0	0.2	2.4	2.7	2.2	3.8 (2006)	9.4 (2007)
Lebanon	8.4 (2011)	2.1 (2003)	7.5 (2011)	0.1 (2008)	0.3 (2008)	..	..	..	..	6.3	1.6	1.6 (2011)	2.8 (1996)
Libya	..	2.1 (2001)	..	..	..	..	..	..	..	4.4	3.0	..	1.23 (2000)
Morocco	13.0 (2011)	2.9 (2011)	12.9 (2011)	4.0 (2008/09)	1.2 (2008/09)	..	..	..	..	6.0	2.1	5.4 (2009)	3.0 (1999)
Oman	7.0 (2011)	..	6.6 (2011)	..	..	..	..	..	..	2.3	1.9	4.3 (2009)	..
Palestine	..	4.0 (2009)	..	..	..	..	..	..	..	..	..	..	..
Qatar	5.2 (2010)	..	2.9 (2010)	..	..	..	..	..	..	1.9	1.5	2.5 (2008)	..
Saudi Arabia	..	..	..	9.7 (2010)	0.2 (2010)	1.1% (2011)[f]	..	..	..	3.7	2.5	5.6 (2008)	..
Sudan	..	..	..	..	..	..	..	..	..	8.4	2.4	..	0.3 (2003)
Syrian Arab Republic	..	1.3 (2004)	..	..	..	..	..	..	..	3.7	1.8	5.1 (2009)	1.2 (1999)

Public expenditure (Cont.) *(Percentage of GDP)*													
	Public sector salaries[a]	Public pension[b]	Subsidies and other transfers			Social transfers				Health, 2011[a]		Public Education[a]	Public social security[c]
			Total[a]	Consumption goods[d]		Social assistance	Family allowance[e]	Disability	Old age	Total	Public		
				Fuel	Food and ration cards								
Yemen	..	1.5 (2004)	..	13.6 (2008)	0.1 (2008)	..	0.1	0.4	0.7	5.5	1.1	5.2 (2008)	4.7 (2004)
OECD	3.7 (2011)	7.7 (2005-2012)	18.9 (2011)	..	..	..	1.4 (2009)[g]	1.6 (2009)[g]	6.0 (2009)[g]	12.3	7.6	5.6 (2009)	..
MENA	..	2.4 (2001-2011)	..	..	..	..	..	..	..	4.4	2.8	4.7 (2008)	7.6 (2006-2008)
Arab region	..	2.4 (2001-2011)	..	..	..	..	..	..	..	4.2	2.6	4.3 (2008)	..
LAC	..	2.7 (2006-2011)	..	..	..	..	..	..	..	7.6	3.8	4.7 (2010)	7.1 (2006-2008)
European Union	5.3 (2011)	9.3 (2007-2009)	25.7 (2011)	..	..	..	..	..	..	10.2	7.8	5.7 (2009)	..
World	6.2 (2011)	4.1 (2001-2012)	13.5 (2011)	..	..	..	..	..	..	10.1	6.0	5.0 (2009)	5.7 (2006-2008)

Notes: Two dots (..) indicate that data are not available.

a World Bank, World Data Bank, 2013, available from http://databank.worldbank.org/data/views/variableSelection/selectvariables.aspx?source=world-development-indicators.

b World Bank Pension Database, Pension Spending (quarter 3), 2013, available from http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALPROTECTION/EXTPENSIONS/0,,contentMDK:23231994~menuPK:8874064~pagePK:148956~piPK:216618~theSitePK:396253,00.html.

c Figure excludes health. ILO, 2010, pp. 258-261.

d Silva and others, 2013, p. 20.

e ILO, 2010, pp. 263-264.

f IMF, 2011a.

g http://stats.oecd.org/#.

ANNEX VII

Welfare initiatives of selected Arab countries, 2010-2012							
Country	Public sector salaries	Public sector employment	Pensions	Subsidies and in-kind transfers	Social transfers	Health and education	Other initiatives
Algeria	May 2011: Wages increase announced[1]			January 2011: temporary tax exemption on sugar and cooking oil[2] May 2011: Food subsidies increase[3]			US$156 billion on new infrastructure projects[4]
Bahrain	August 2011: Minimum wage increase[5] August 2011: Pay increase[6] September 2011: US$1031 (Bahraini dinars: 388.5) million for public servants pay increases[7]		August 2011: Minimum public and private sector pension introduced[8] March 2012: Private sector pension 3 per cent increase[9]	February 2011: Increase in food subsidies[10]	Allowance to all families of US$2,650[11]	August 2011: National Social Fund to sponsor childhood development services, elderly care, education and rehabilitation of the disabled and family development services[12]	March 2011: GCC countries pledge US$20 (Saudi Arabian rials: 75) billion to create jobs and implement a range of development projects in Bahrain and Oman[13] January 2012: US$551 million to build affordable housing[14]
Egypt	June 2011: Public servant wages increase[15] July 2011: Minimum wage increase[16]	Decreased public sector employment 2010/2011-2011/2012[17]		January 2011: New cabinet was ordered to maintain subsidies[18]			The cabinet approved a budget of US$71 (Egyptian pound: 490.6) billion for fiscal year 2011-2012 for social programmes[19]
Iraq	November 2011: Increase in salaries[20]		November 2011: Increase in pensions[21]	February 2011: Food rations for the poor reintroduced[22]			May 2011: US$2 billion to build low cost housing[23]

Welfare initiatives of selected Arab countries, 2010-2012 (Cont.)							
Country	Public sector salaries	Public sector employment	Pensions	Subsidies and in-kind transfers	Social transfers	Health and education	Other initiatives
Jordan	January 2011: Wage increase announced[24] August 2011: One-off payment of US$141 (Jordanian dinar: 100) to all serving and retired public servants[25]	March 2011: Government to create 21 000 jobs, 6 000 of which will be in the Public Security and Gendarmerie departments[26]		January 2011: Kerosene and diesel taxes cancelled, gasoline taxes reduced and sugar and cooking oil subsidized[27] September 2011: Bread subsidies continued[28]		July 2011: Funding for health and education Development projects in Karak governorate[29] July 2011: US$14 (Jordanian dinar: 10) million in support for Mutah University and initiation of survey of the medical and education sectors to improve quality of services[30]	March 2011: US$57 (Jordanian dinar: 40) million to implement projects in the poorest areas of the country[31] June 2011: US$21 (Jordanian dinar: 15) million to establish Tafileh Development Fund to provide development and income-generating projects in the Tafileh governorate[32] The creation of a US$ 212 (Jordanian dinar: 150) million fund for the development of the country's governorates. The fund will be run by the Government and civil society, and seeks to create jobs and enhance the living conditions of citizens[33]
Kuwait	July and September 2011: Wage increases[34] March 2012: 40 per cent salary increase[35]			February 2011: Distribution of free food to eligible citizens for 14 months[36] July 2011: Food subsidies extended to Bedouins[37]	February 2011: One-off payment of US$3540 (Kuwaiti dinar: 1000) to every Kuwaiti citizen[38] November 2011: Increase in student allowance[39]		

Welfare initiatives of selected Arab countries, 2010-2012 (Cont.)							
Country	Public sector salaries	Public sector employment	Pensions	Subsidies and in-kind transfers	Social transfers	Health and education	Other initiatives
Lebanon	September 2012: Wage increase announced[40]			April 2011: Flour subsidies increased[41] May 2011: Fuel subsidies for transport workers increased[42]			October 2011: Announced increase of minimum wage by 40 per cent (yet to be fully implemented)[43]
Libya	February 2011: 150 per cent pay raise for some workers[44]			January 2011: Abolition of taxes and customs duties on food[45]	February 2011: US$450 allowance to help families deal with rising food costs[46]		
Morocco	April 2011: Increase in the salaries of civil servants by US$73 (Moroccan dirham: 600)[47]			February 2011: US$2 billion in subsidies to curb price hikes for staples[48]			October 2011: Plans announced to have companies contribute to a new social solidarity fund[49]
Oman	January 2012: Teachers salaries increase[50]	February 2011: 50 000 public service positions created[51]	February 2011: Improved public sector pensions[52]	December 2011: Food subsidies introduced[53]	February 2011: US$390 monthly allowance for job seekers introduced[54]	October 2011: launched the National Programme for the Elderly (Home Care)[55] February 2012: Funding boost for hospitals[56]	February 2011: Minimum salary increase[57] March 2011: GCC countries pledge US$20 (Saudi Arabian rial: 75) billion to create jobs and implement a range of development projects in Bahrain and Oman[58] November 2011: launch of SMEs Loans Guarantee Programme[59] April 2012: Increased funding for social housing programme[60]

Welfare initiatives of selected Arab countries, 2010-2012 (Cont.)							
Country	Public sector salaries	Public sector employment	Pensions	Subsidies and in-kind transfers	Social transfers	Health and education	Other initiatives
Qatar	September 2011: Substantial salary increase announced[61]						April 2011: Increased availability of housing loans for nationals[62]
Saudi Arabia	February 2011: Minimum wage of set at US$800 (Saudi Arabian rial: 3 000) Two months' salary bonus[63] Inflation allowance for state employees extended indefinitely[64]	February 2011: 60 000 new public servants jobs established[65]		July 2011: Cattle feed subsidy increase[66]	February 2011: Two month financial aid for all students and US$533 (Saudi Arabian rial: 2 000) monthly aid for all job seekers[67] March 2012: More than one million Saudis now receive unemployment benefits[68]	February 2011: US$4.3 (Saudi Arabian riyal: 16) billion allocated to the Ministry of Health to expand medical services in all governorates and establish new health centres for medical treatment and research. Funding for private hospitals increased from US$13.3 (Saudi Arabian riyal: 50) million to US$53.3 (Saudi Arabian riyal: 200) million[69]	February 2011: Approx. US$66.7 (Saudi Arabian riyal: 250) million allocated to establish 500,000 housing unit for Saudi nationals. Housing loan provided by the Real Estate Development Fund increased from US$80 000 to US$133 000 (Saudi Arabian riyal: 300 000 to Saudi Arabian riyal: 500 000)[70] Inject capital into specialized credit institutions to facilitate debt write-offs and increase mortgage lending[71]
Syrian Arab Republic	March 2011: Salaries increase[72]	May 2011: 50 000 public jobs to be created for youth and permanent jobs given to 105 000 public employees[73]		February 2011: Heating allowance increase[74] February 2011: Customs duties and taxes on certain food items decrease[75]	Increased funding to the Social System Fund for the poor[76]	May 2011: For every 5 year contract in private establishments, the Government will pay one year salary[77]	July 2011: Government housing project to create affordable housing and employment launched[78]

Welfare initiatives of selected Arab countries, 2010-2012 (Cont.)							
Country	Public sector salaries	Public sector employment	Pensions	Subsidies and in-kind transfers	Social transfers	Health and education	Other initiatives
Tunisia	August 2011: 4.7 per cent Increase in wages[79]	2011: Permanent job creation scheme providing 24 000 jobs in the civil service and 10 000 in semi-state bodies[80]		Increase in food subsidies[81]	2011: New programme providing half-time work in civil service together with monthly allowance of US$91 (Tunisian dinar: 150), health insurance and reduced public transport fares[82]		January 2012: approval of a budget of approx. US$14 (Tunisian dinar: 23) billion, a 7.5 per cent increase from previous year, primarily for social development[83] August 2011: 4.7 per cent increase in private sector wages[84]
United Arab Emirates	December 2011: Federal public salaries increase 45 per cent[85]	May 2011: 150 new government jobs to be created[86]	70 per cent increase in pensions for military personnel[87]	March 2011: Rice and bread subsidies[88] October 2011: Free water quotas for eligible citizens increase[89]			Infrastructure stimulus programme focusing on the Northern Emirates[90]
Yemen	February 2011: 30 per cent salary increase for public sector employees and the army[91]	February 2011: Instructions that 25 per cent of university graduate (approx. 60 000) are provided jobs in the public sector[92]			Social welfare fund expanded to cover 500 000 additional families[93] Interim monthly stipend for recent graduates[94]	February 2011: Students exempted from paying tuition fees[95]	January 2011: 50 per cent tax cut on salaries[96]

Endnotes

ENDNOTES

Chapter I
WELFARE POLICIES OVER TIME

1. Silva and others, 2013, p. 32.
2. Powell, 2007.
3. Huber, 1996, p. 146.
4. Haggard and Kaufmann, 2008, p. 1.
5. Schwartz and Ter-Minassian, 2000, p. 338.
6. Esping-Anderson, 1990, p. 18.
7. Ibid., p. 25.
8. Haggard and Kaufmann, 2008, p. 12.
9. For this reason, family care is not discussed deeply in this report, but is subject of a separate study project. See also: ESCWA, 2013a.
10. Hansmann, 1987, pp. 28-30.
11. Abdou and others, 2010, pp. 2 and 7.

Chapter II
PUBLIC SECTOR PRODUCTION OF WELFARE

1. For further information see annex I.
2. Detailed coverage rates are provided in annex II.
3. See annex III and annex IV.
4. For data on severance pay and notification period, see World Bank, 2011a, pp. 141-142.
5. Silva and others, 2013, p. 110.
6. Ibid., pp. 135-140.
7. Ibid., pp. 135 and 136.
8. Loewe, 2004, p. 413.
9. Nasr, 2001, p. 41.
10. Silva and others, 2013, p. 106.
11. Korayem, 2011, p. 2.
12. El Mekkaoui and Johnson, 2012, p. 10; and Silva and others, 2013, p. 124.
13. El Mekkaoui and Johnson, 2012, p. 10.
14. Palacios and Sluchynsky, 2006, p. 10.
15. Silva and others, 2013, p. 135.
16. Ibid., pp. 117-119.
17. ESCWA and the League of Arab States, 2013, p. 15.
18. Marotta and others, 2011, p. 20.
19. ESCWA and the League of Arab States, 2013, pp. 4-5.
20. Ibid., pp. 26-31.
21. Ibid., pp. 17-20.
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24. WHO, 2006a, p. 34.
25. Al-Halawani and others, 2006, p. 54.
26. African Development Bank, 2012, p. 26.
27. Nakhimovsky and others, 2011, p. 41.
28. World Bank, 2012a. The indicators are: infant mortality rate, under 5 mortality rate, stunting, underweight, diarrhoea, acute respiratory infection, fever.
29. Partnerships for Health Reform, 2001, p. 29.
30. The World Bank sets the threshold of catastrophic payments at 10 per cent of total household income. The assessment included Egypt, Lebanon, Tunisia, the West Bank and Gaza and Yemen. Elgazzar and others, 2010, p. 12.
31. Yemen National Health Accounts Team and Partners for Health Reformplus, 2006, p. 25.
32. WHO, 2006b, p. 24.
33. Qatar, Supreme Council of Health, 2011, p. 26.
34. Nakhimovsky and others, 2011, p. 22.
35. World Bank, 2009, p. 140.
36. Ibid., p. 101.
37. ESCWA and the League of Arab States, 2013, pp. 17-18.
38. UNESCO, Education for All Global Monitoring database, accessed 6 May 2014.
39. USAID, 2004, p. 26.
40. World Bank, 2009a, p. 26.
41. African Development Bank, 2012, p. 26.
42. UNESCO, 2010, pp. 161 and 163.
43. USAID, 2004, pp. 11, 18 and 26.
44. Salehi-Isfahani and others, 2012, p. 3.
45. World Bank, 2009a, p. 12.
46. Ibid., p. 27.
47. ILO and UNDP, 2012, p. 78.
48. Kawar and Tzannatos, 2012, p. 3.

Chapter III
THE PRIVATE SECTOR
Commercial Provision of Social Services and Corporate Philanthropy

1. Cammett, 2013, p. 20.
2. Knowledge and Human Development Authority, 2013, p. 11.
3. World Bank, World Development Indicators Database 2012.
4. Knowledge and Human Development Authority, 2013, p. 15.
5. Ibid., pp. 7-10.
6. Ibid., p. 6.
7. http://www.localiban.org/spip.php?article5190.
8. Cammett, 2013, pp. 32-33, See also chapter V for a detailed description of civil society provision.
9. Kronfol, 2004, p. 29.
10. Kronfol, 2012b, p. 1230, 1234.
11. Saeed, 2011, p. 24.
12. Arfa and Elgazzar, 2013, p. 3.
13. Sen and Faisal, 2012, p. 174.
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23. WHO, 2006b, p. 20.
24. International Social Security Association, 2008.
25. WHO, 2006c, p. 23.
26. IRIN, 2004.
27. WHO, 2006e, p. 19; WHO, 2006f, p. 19.
28. Robalino, 2005, p. 40.
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54. Nandakumar and others, 2000, p. 193.
55. WHO, 2006c, p. 73.
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57. Skoun, 2011, p. 5.
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Chapter IV
CIVIL SOCIETY AND ITS ROLE IN THE PROVISION OF SOCIAL SERVICES

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51. World Bank, 2012b, p. 45.
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62. Harmsen, 2008, p. 260.
63. Ibid, p. 254.
64. Lundblad, 2011, pp. 26 and 170.
65. Harmsen, 2008, p. 257.
66. Baylouny, 2010, p. 125.
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Chapter V
TOWARDS A NEW WELFARE MIX?

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When the long-simmering social crises in Arab countries erupted to the surface in 2011, these events immediately shifted government attention from the economic to the social field. Suddenly it became clear that years of substantial economic growth had not improved social outcomes and Governments rushed to increase public employment and wages, improve services, increase social transfers and invest in social infrastructure. However, Governments and societies are aware of their need to find more sustainable ways to solve structural socioeconomic and political problems. Changes in the policy sphere may open the way for a different approach to social development that will be more inclusive of people of all ages, regions and income groups, and grant more equitable access to social protection and social services.

This Report explores the prevailing welfare mix in Arab countries, the contribution of different private sector enterprises and civil society actors to social protection and social services, and the advantages and difficulties emerging from the current situation. It does not aim to provide a comprehensive inventory but rather looks at issues such as education or health-care services on the basis of examples from selected countries.

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