Do spending choices add up to equity – or stand in the way?

03

Over the past two decades, nearly all Arab countries have made significant investments in improving health and education and reducing poverty. Yet, development gains have not reached all members of societies. The region is among the most unequal in the world,[76] with dramatic differences in wealth and well-being.[77] Decades of providing welfare entitlements in exchange for political acquiescence[78] largely produced a situation where development "enhances access but undermines agency, expands consumption possibilities but impairs human capabilities".[79] The weaknesses of this approach are increasingly evident in both the region's yawning development gaps and the calls for justice and a new social contract echoing from its citizens.[80]

Improving the equity of public social expenditure in terms of amounts and spending choices would go far in rectifying some of the most troubling disparities and accelerating social justice.[81] Social justice ensures equal rights and access to resources and opportunities for all. It pays particular attention to removing barriers to disadvantaged groups and their abilities to make decisions about their lives,[82] in line with the principle of equity enshrined in seminal international human rights conventions. The SDGs are grounded in equity and equality considerations, with their explicit call to ask who is benefitting and who is left behind (box 2). Further, strong, sustained economic growth depends on reducing inequality to expedite social mobility and develop all sources of human capital.

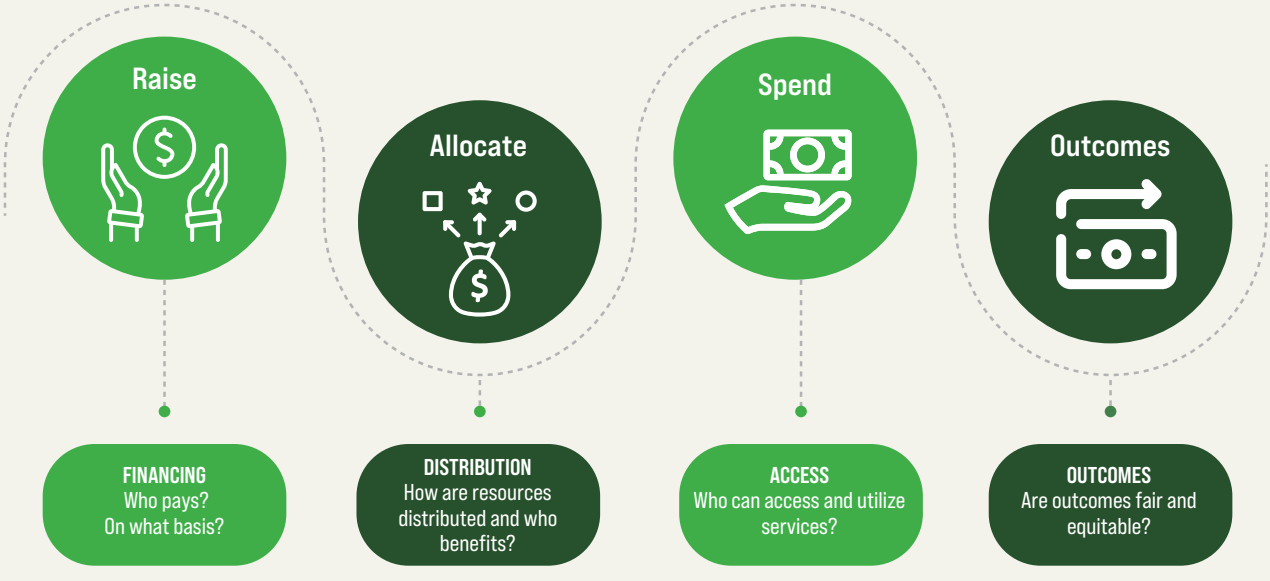
The equity of social expenditure can be assessed in four stages: how revenue is raised, how it is allocated among sectors, how it is spent within sectors, and how it contributes to equitable outcomes (figure 33). This chapter considers the allocation, spending and outcome stages in particular. It argues that the quality of social spending determines its potential to mitigate societal inequalities and help overcome systemic barriers for marginalized population groups.

Box 2. Equality and equity: What's the difference?

Equality is concerned with all individuals receiving equal treatment regardless of need or any other difference. Inequality at a societal level is often replicated through disparities in access to social services and related social outcomes.

Equity denotes fairness and centres on ensuring that all individuals have what they need to succeed. In recognizing that individuals do not all start from the same place, equity requires adjustments to imbalances. Since equity may involve "positive" discrimination against certain groups that were better off prior to an intervention, pursuing it may prove controversial and encounter pushback.

Figure 33. Four stages for assessing the equity of social expenditure



Source: Adapted from UNICEF's PF4C chain.

A. Finance must be adequate and reach people furthest behind

From an equity perspective, achieving efficiency in expenditure entails not just ensuring that resources produce intended broad development outcomes, such as health and education goals, but that they are intentionally distributed to prioritize accelerated advances for population groups furthest behind.[83] Understanding the degree of support for equity requires looking at how expenditures are distributed across different social sectors and across spending choices within each sector, as well as how policy choices translate into the distribution of spending across beneficiary groups. A look at allocations across and within sectors considers three primary spending categories – health, education and social protection – to shed light on the current situation in Arab countries.

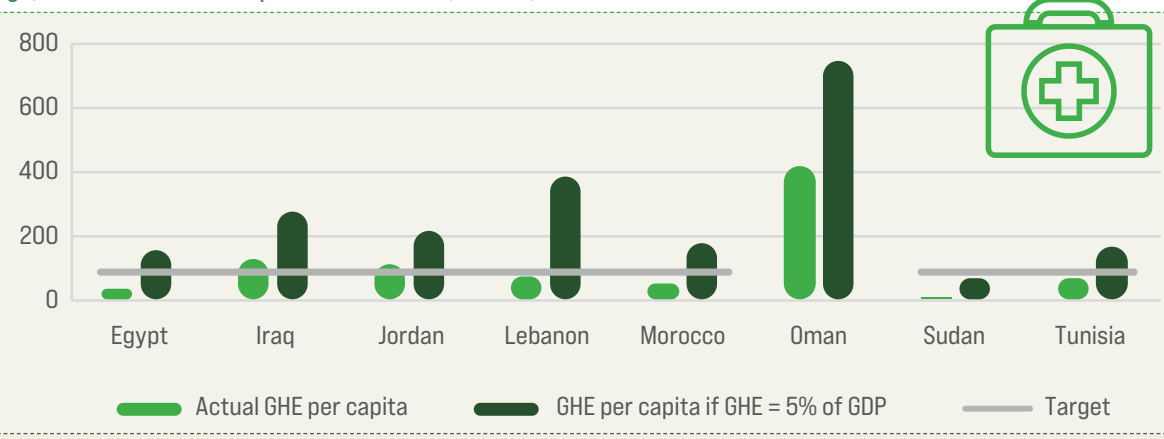
1. Linking spending adequacy and equity

Analysing allocations among sectors reveals the link between the adequacy and equity of spending. If social spending is inadequate, critical services will be short-changed. Populations will either have to go without access to these services or pay privately for them. Privileged groups will have a greater ability to pay privately, and, therefore, will be less likely to forgo essential services. If disadvantaged groups do access private services, they are at greater risk of experiencing catastrophic expenditure, such as for a health crisis. As the relative contribution of regressive direct payments is directly related to the adequacy of public expenditure, there is a clear connection between equity and adequacy.

Social spending in many Arab countries remains insufficient. The region consistently fails to meet international benchmarks such as for Government health expenditure to constitute 5-6 per cent of GDP as a path towards realizing the SDG commitment to universal health coverage.[84] None of the low and middle-income Arab states with available SEM data reach even 5 per cent. They also score poorly on public health spending per capita. Iraq and Jordan exceed an $86 per capita benchmark (2018 dollars) considered a minimum for providing essential services in low-income and lower-middle-income countries.[85] Yet, Jordan, as an upper-middle-income country, likely has higher health-care costs. Egypt, Morocco and Tunisia, all lower-middle-income countries, would reach the $86 per capita target if they allocated 5 per cent of GDP to public health spending. Prospects for the Sudan are less promising given the limited size of its economy and fiscal space. Even if it met the 5 per cent target, it would still fall short of delivering essential health interventions (figure 34).

Arab countries perform better on education allocations, based on benchmarks set in the Education 2030 Framework.[86] This aims for education expenditure to account for 15-20 per cent of overall public spending and between 4-6 per cent of GDP (figure 35). Morocco and Tunisia meet or exceed both benchmarks. Oman also performs well. Egypt and the Sudan allocate the smallest proportion of their budgets and GDP to education, despite large shares of children in their populations. More than 50 per cent of population of the Sudan is under 19 yet it spends less than 1 per cent of GDP on public education. In general, countries with the highest commitments to public education have the smallest school-age populations, defined as the share below age 19 (figure 36).

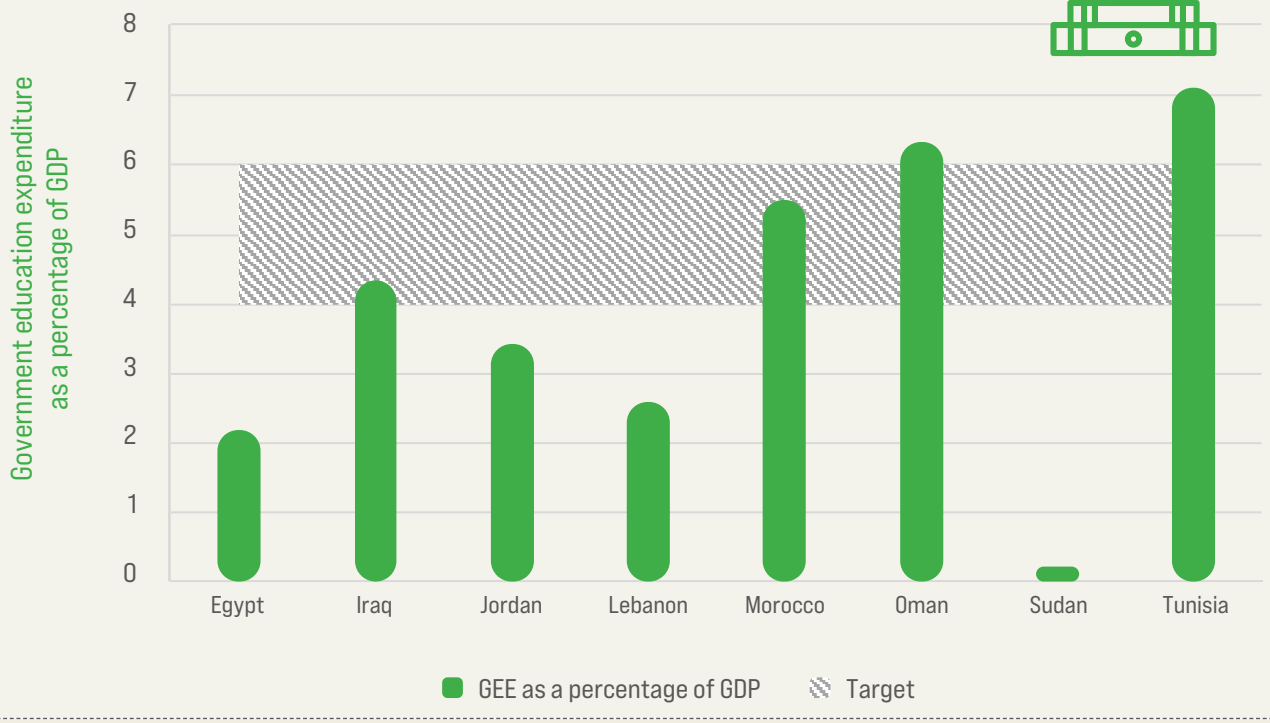
Figure 34. Government health expenditure per capita falls short of the level required to move towards universal health coverage, a fundamental for equitable societies (Dollars)



Source: ESCWA, n.d.a.

Note: Data are from 2019 for all countries except the Sudan, where they are from 2016. The authors used SEM data for converting spending into dollars per capita, except for the Sudan, where they used World Bank data for GDP per capita. GHE stands for Government health expenditure.

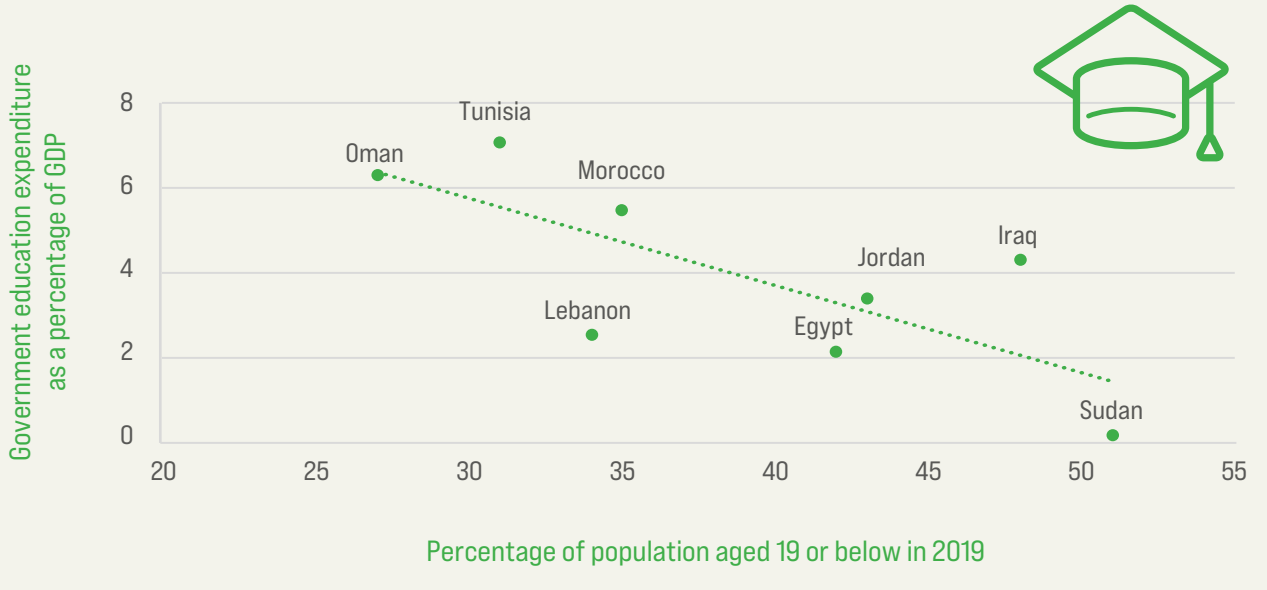
Figure 35. Some countries meet international benchmarks for public educational expenditure



Source: ESCWA, n.d.a; UNDESA, 2019.

Note: Data are from 2019 or the latest available. GEE stands for Government education expenditure.

Figure 36. Countries with higher commitments to public education have smaller shares of people aged 19 and below



Source: ESCWA, n.d.a; UNDESA, 2019.

Note: Population by age includes both sexes. GEE stands for Government education expenditure.

Insufficient public spending on education has similar impacts to those seen in health, leading to potential forgone service use or regressive household expenditure on private services. Further, as education is an important catalyst of socioeconomic equality, inadequate expenditure deprives children of a fairer start in life. Long-term intergenerational implications include trapping poorer and disadvantaged children in cycles of poverty.

International benchmarks for spending on social protection have not been broadly adopted by countries, largely due to shortfalls in resources to meet expenditure needs. For the Arab region as a whole, public expenditure on social protection is just 4.6 per cent of GDP, among the lowest levels in the world.[87] The only region with a lower allocation is Africa, at just 3.8 per cent. According to SEM data, only Iraq at 16 per cent exceeds the world average allocation of 12.9 per cent, largely due to energy subsidies. Limited fiscal space in the Sudan is a challenge to allocate higher public social protection expenditure, a real concern given high levels of poverty and vulnerability. Constrained investment in social protection across the region likely fuels stubbornly high inequality and low levels of social mobility.

2. Investing first in services to dismantle barriers to rights and development

Spending choices within sector budgets can support equity by investing first and most in services most likely to be used by people who are poor and vulnerable. Such expenditure choices are more likely to dismantle barriers from underdevelopment and discrimination and are often highly cost-effective. Primary health care, for instance, is well placed to improve equity in health[88] if it is readily available to all. Such services cover not only broad swathes of populations, including vulnerable populations such as children, but also tend to be heavily used by poorer people. They facilitate access to generalist and life-saving care, including immunizations, as well as referrals to specialist care.

Egypt, Jordan and Tunisia have data on allocations to primary health care as a proportion of Government health expenditure. Only Jordan, with half of health expenditure going to primary care, is in line with the global average of 51 per cent.[89] Egypt allocates 46 per cent of health expenditure to primary care; Tunisia provides 44 per cent. While Egypt and Tunisia do not fall very far short of global averages, the adequacy and equity of their allocations must be considered in terms of broader health commitments. Against the $86 per capita spending threshold for essential health services, for instance, many of which fall in the realm of primary care, Egypt spends only $17 per person on primary care and Tunisia spends $29. In contrast, Jordan spends $55. In other words, not prioritizing services most likely to benefit the poorest translates into underfunding basic benefit packages.

A study that established investment guideposts and projected health-care resource needs for 67 low- and middle-income countries, including Egypt and Tunisia,[90] found that on average, if countries implemented a basic package of health-care measures by 2030, 30.6 million deaths would be averted and four years of life expectancy gained. Between 2020 and 2030, Egypt would need to spend an additional $31 per capita per year to provide basic services. Tunisia would need to spend an extra $33 per capita per year.[91]

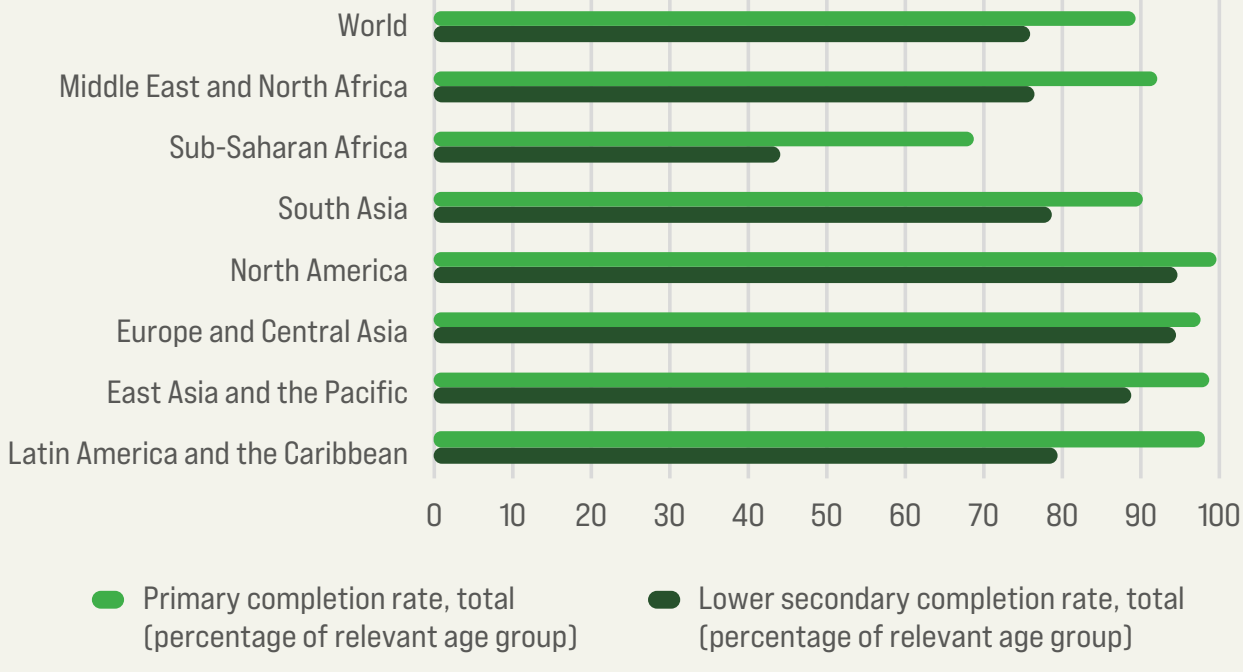
In education, investment in different levels of schooling has implications for equity. In particular, investments in early childhood education can achieve high health, economic and social outcomes[92] and mitigate early disadvantages related to poverty and gender.[93] But the Arab region broadly fails to allocate sufficient proportions of education budgets to early childhood education. The latest data suggest that the Governments of Bahrain, Djibouti, Morocco, Oman, and the Syrian Arab Republic spend

very little if anything on pre-primary education. In Jordan and Tunisia, expenditure on early childhood education is less than 1 per cent of that for primary and secondary education.

Many Arab countries do not deliver public early childhood education through the Ministry of Education. The United Nations Educational, Scientific and Cultural Organization (UNESCO) found that among 19 Arab States, only Algeria had legal provisions for free early childhood education. No country had compulsory provisions for it.[94] Some countries have begun adopting positive reforms, such as Morocco, which in 2020 made it mandatory for children to attend preschool for one year. The Ministry of Education is expected to become more involved in supervising services provided by private institutions, in addition to increasing public provision of preschool services.[95] For children from poorer families in Morocco, the absence of free or subsidized public provision of early childhood education is an obvious barrier. Fees for private sector alternatives, which currently account for over 80 per cent of Moroccan children enrolled in early childhood education,[96] may simply be out of reach.

Arab countries also vary in the sufficiency of secondary school expenditure compared with the size of the relevant age group, generally from ages 10-19. Public spending on secondary education in Djibouti, Lebanon and Qatar exhibits this misalignment. Djibouti displays the worst allocation, with the share of spending almost 40 times smaller than what would be expected based on the secondary school-age population share. For some Arab countries, publicly provided education does not extend to the completion of secondary school, leaving poor households facing a large financial burden to continue their children's education. This means that while the region does relatively well on its average primary school completion rate, its average secondary school completion rate lags almost all regions except Africa (figure 37).

Figure 37. The region lags almost all other regions in lower secondary school completion, 2019



Source: World Bank, n.d.b., based on data from the UNESCO Institute for Statistics.

In contrast to secondary education, the share of public expenditure on tertiary education is equal to or greater than the population share of the relevant age group. Only Bahrain, Morocco and Oman have near parity between expenditure and age shares. Expenditure is strongly skewed in Djibouti, Jordan, Lebanon, Qatar, and the Syrian Arab Republic. Without specific provisions for poor and vulnerable populations to access tertiary education, however, such as through scholarships or affirmative action, tertiary education services tend to deliver higher benefits to people in upper-income quintiles. Overprioritizing tertiary education in public education budgets without specific provisions for the poor may exacerbate inequity by consuming resources that could otherwise be targeted towards more inclusive earlier levels of schooling, including early childhood and secondary levels, where appropriate.

In providing social protection, the share of spending going to the poorest quintile of a given population has a direct impact on reducing poverty and inequality.[97] A 1 percentage point increase in the share of social protection spending reaching the poorest quintile can deliver a 0.34 percentage point reduction in the poverty headcount[98] and a 0.44 percentage point reduction in the Gini index.[99] The IMF has suggested that raising per capita social protection spending by 10 per cent in purchasing power parity dollars for three years could close 20-40 per cent of the human development gap between countries in the Middle East and North Africa and comparator economies outside the region.[100]

In Arab countries, the beneficiaries of public social protection generally differ between social insurance and social assistance. On average, in non-GCC Arab countries, almost two thirds of the labour force do not contribute to social security and are not covered by any pension or health insurance scheme.[101] The largest excluded groups in most countries are agricultural workers, household and family workers, and foreign migrant workers.

Most Arab countries have minimum pension arrangements that entail redistribution within pension funds in favour of those covered with the lowest incomes. Such programmes have mostly benefited the urban lower-middle class, however, since rural populations and poorer urban groups are not covered by the contribution-based social insurance that predominates. This exacerbates inequities.[102]

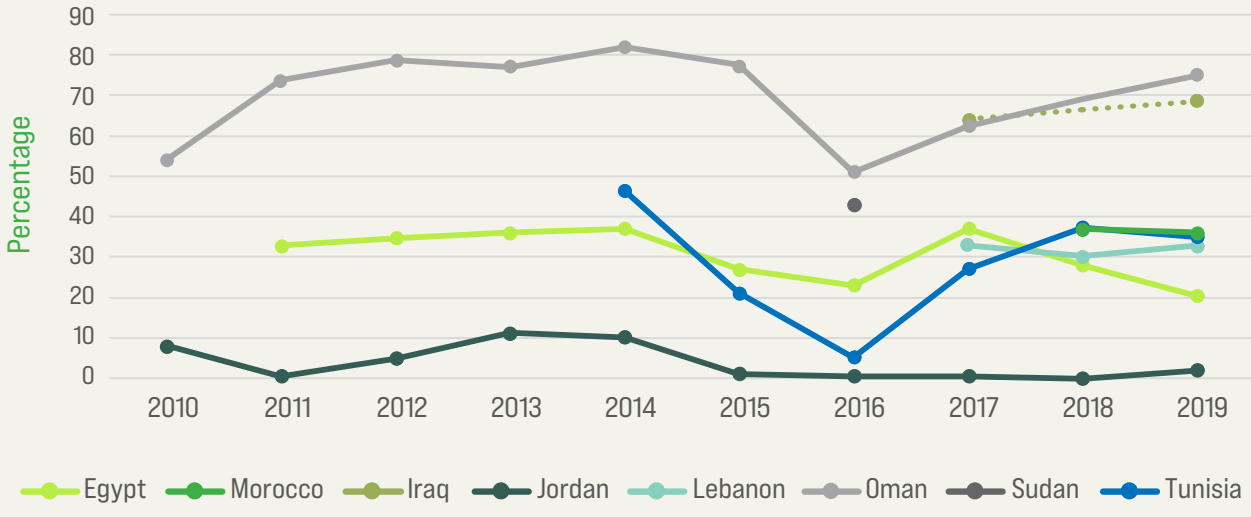
The second tier of social protection is social assistance, a diverse range of cash transfers and subsidies that are part of social protection systems.[103] Most countries combine general price subsidies and targeted social assistance. Subsidies apply to a range of commodities, including fuel, food and housing, with the main objective being to reduce poverty by improving access to goods and services.[104]

In the share of overall public expenditure on social protection, subsidies and support to farms that is spent on fuel and electricity subsidies, Jordan has the lowest share; Iraq and Oman the highest. Egypt has also had significant subsidies over the past decade, but often with a regressive nature. This is particularly the case with energy subsidies, where richer households benefit more than the poorest households, for reasons that include greater consumption of the subsidized goods.[105] Of all forms of energy subsidies, those for gasoline, diesel and electricity – the focus of the SEM data – are the most regressive (figure 38 and box 3).

Social spending in the Arab states is lower than established international benchmarks.

Figure 38. Spending on fuel and electricity subsidies as a share of the social protection, subsidies and support to farms dimension of the SEM

Spending on subsidies for fuel and electricity is often regressive, with richer households consuming and benefitting more



Source: ESCWA, n.d.a.

Note: Dotted trendlines indicate missing data points.

Box 3. A look inside energy subsidies and the impact on poverty in Tunisia

Fiscal reforms have impacts on inequality and poverty through what people pay and receive for different subsidized products and services. In Tunisia, energy subsidies constitute the main component of total subsidies, including food and transport. They are also the country's most controversial fiscal policy tool. Initially designed to protect the most vulnerable households and foster domestic industrial growth, the subsidies can in fact increase inequality and poverty.

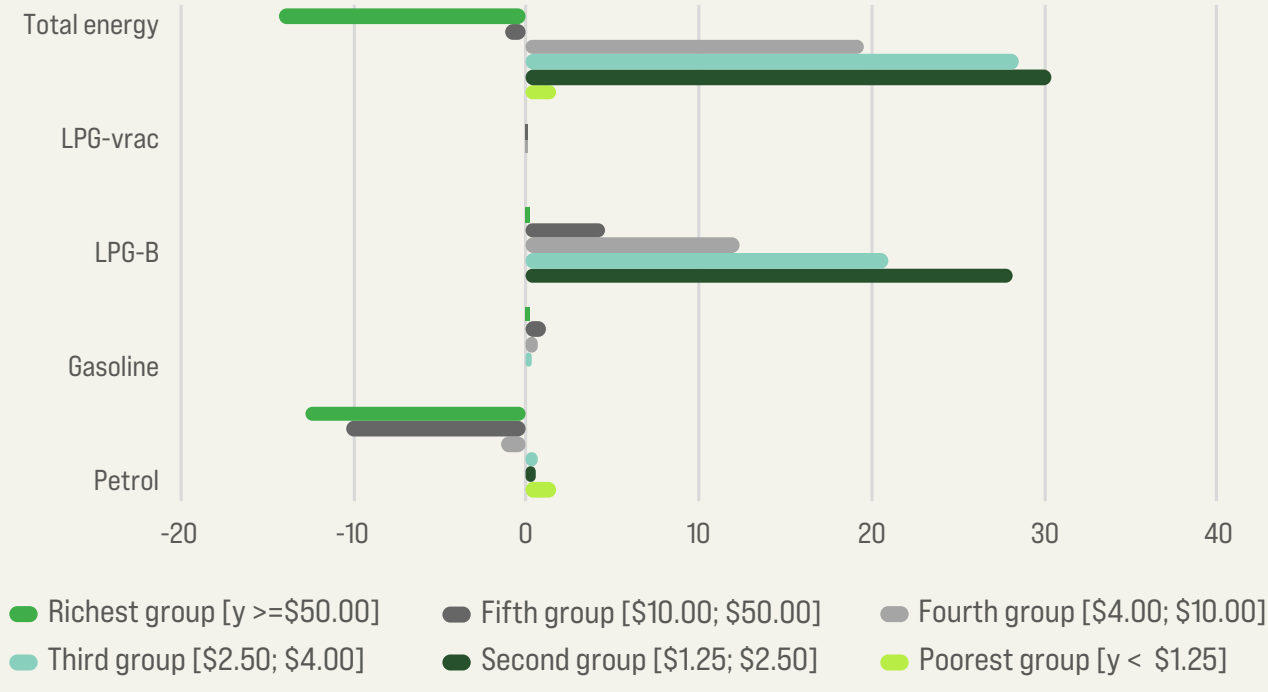
Fiscal incidence analysis is a way to examine the direct impact of subsidies, taxes and transfers on poverty and inequality. It compares disposable income (net of income after paying direct taxes and receiving direct transfers) with the post-fiscal income (disposable income plus net of indirect taxes and indirect subsidies from consuming goods and services) using the commitment to equity assessment methodology.

In Tunisia, based on this analysis, net impact of indirect taxes (on goods and services) and indirect subsidies (on energy and food) result in poverty and income inequality reduction. In 2018, the Gini coefficient for post-fiscal income was lower, at 0.31, compared to 0.33 for disposable income. Similarly, considering all taxes, direct cash transfers and indirect subsidies, the national poverty rate for post-fiscal income would decrease to 11.6 per cent compared to 15.2 per cent for disposable income.

Energy subsidies are significant in Tunisia. They are estimated at 8.8 per cent of household expenditures. Cutting energy subsidies could impact poverty and income inequality in different manners, depending on the type of subsidy. The per capita consumption of energy (quantity) and spending (prices) varies across quintiles, with high consumption in the richest quintile. Variations in consumption also depend on the type of energy product. The largest consumption differences are for gasoline, followed by diesel and electricity. A richer individual consumes 4.5 times more electricity and 1.4 times more LPG than an individual from the poorest household. For electricity, increases in prices for consumption above 400 kilowatt hours per month have reduced shares going to upper quintiles, an example of a policy to promote greater equity.

In terms of spending, the richest quintile of households spends six times more on residential energy than that of the average household in the poorest quintile. Variations across quintiles are less acute for LPG and electricity. The distributive impact of energy subsidies is heterogeneous, with LPG in bottles (LPG-B) being the most influential among the lower income population. The incidence of subsidies net of taxes (percentage of disposable income) is more pronounced for LPG-B for the lower second and third group of population (figure). Consequently, removing LPG subsidies will have a huge impact on the poor, given that LPG comprises 90 per cent of the energy they use. This would raise the poverty headcount by an estimated 0.7 percentage point.[a] Such an outcome underlines the value of energy subsidy reform that targets the type of energy and its distributional impact in addition to fiscal savings.

Incidence of energy subsidy net of tax by socioeconomic group



Source: Moummi, 2021.

Note: Groups are classified by disposable income per day per capita thresholds.

[a] World Bank, 2020.

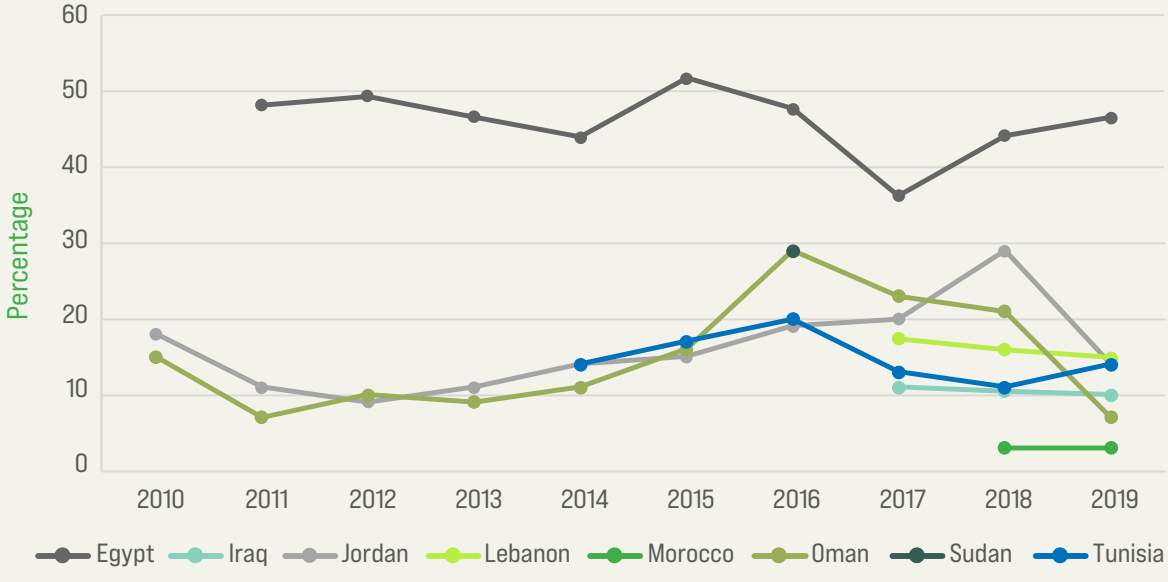
Food subsidies may support equity, in contrast, as the poor spend a higher share of their income on food. Many food subsidies in Arab countries reach the poor through ration cards, such as in Egypt,[106] or through subsidies aimed at lower-quality products less likely to be consumed by the rich. Despite efforts to target such support to the poor, however, the rich often reap benefits disproportionate to their food needs. In Egypt, more than 88.5 per cent of all families benefit from the food subsidy system, for instance.[107] The leakage rate to non-poor households is approximately at 78 per cent, and the undercoverage rate of poor households is at around 9 per cent.[108] Some Arab States are attempting reforms of food subsidy systems to improve efficiency and reduce leakages[109] but these have received less attention than reforms to change fuel prices and electricity tariffs. This reflects the comparatively small fiscal cost of food subsidies and their high social sensitivity as demonstrated by the ongoing food inflation trends.[110]

Targeted support constitutes the other key part of social protection systems in the Arab region, through various cash or in-kind transfer programmes as well as housing support and

other benefits.[111] Data from almost 10 years ago suggested comparatively high absolute expenditures on social assistance relative to other regions, driven mainly by fuel and food subsidies, which constituted 5.7 per cent of GDP.[112] Since then, most Governments have increased the prioritization of cash transfers within social protection. However, since a key objective of major reforms has been to reduce budget deficits overall, only a share of savings goes to new cash transfers (figure 39). In Egypt, almost half of public spending on social protection and food security is for cash or in-kind transfers that support income or families and children.

Figure 39. Cash and in-kind transfers as a share of total public expenditure on the social protection, subsidies and support to farms dimension of the SEM

Increased cash and in-kind transfers to families and children have been offset by reforms to cut budget deficits



Source: ESCWA, n.d.a.

Note: Dotted trendlines indicate missing data points.

B. Too often, spending reflects and reinforces inequities

Public social expenditure amounts and choices influence which services are provided, to which groups and in which locations. If out-of-pocket costs are high, making up for shortfalls in public funds, financing may embed inequities (box 4).

Various indicators for access to health care reveal inequities within countries, and these are tied to country classification. Countries were grouped in the following three sets for comparison: low-income countries, middle-income countries, and countries with fragile and conflict affected situations (figures 40 through 42).[113] With a few small exceptions, even the richest quintile of people from the low-income countries with fragile and conflict-affected situations has less access to health care than the poorest quintile in the middle-income countries. Inequity in the second set of countries is also high but slightly less pronounced. The wealthiest populations in countries with fragile and conflict-affected situations are better able to maintain

access to health care during crises compared to other income groups in the same country and compared to wealthy groups in low-income countries with fragile and conflict-affected situations. This likely relates to the proliferation of private health care in countries with fragile and conflict-affected situations for those who can afford it. The absence of a functioning State allows private provision to evolve without regulation or integration into either provincial or national strategies.[114]

In the Arab region

Unpooled out-of-pocket payments

27%

of current health expenditure

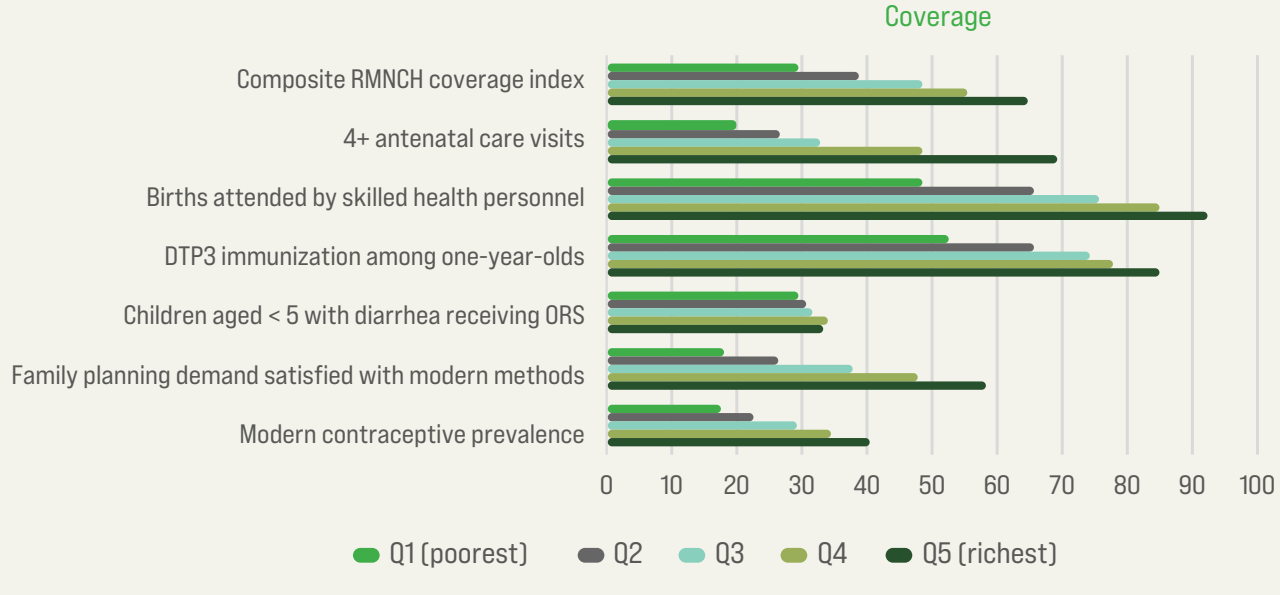
= barrier to access health services for poor and disadvantaged groups

Box 4. Out-of-pocket payments and equity

Direct or out-of-pocket payments for a service are usually at a flat rate without considering the ability to pay. They are the most common form of private financing for social services but directly contradict the principle of equitable financing, where the burden of financing is spread equitably across the population through some form of pooled funding. Out-of-pocket payments mean access is determined by the ability to pay rather than need, a significant barrier especially for poor and disadvantaged groups.

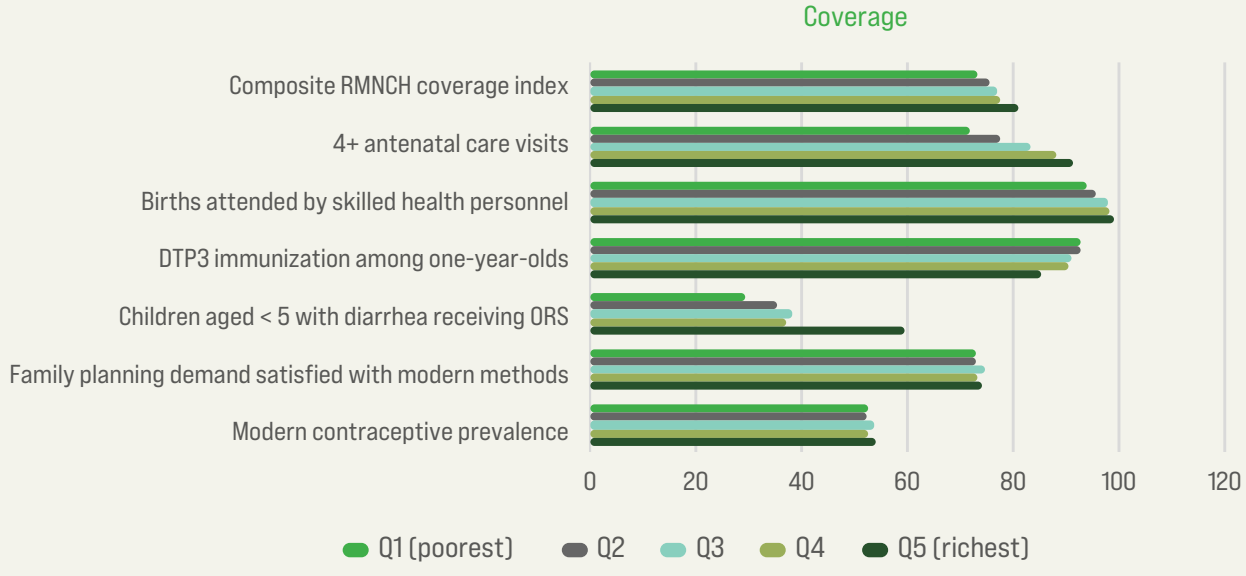
An average of 27 per cent of current health expenditure in the Arab region is raised through unpooled out-of-pocked payments; the share is 46 per cent when excluding the GCC countries. This compares poorly against the world average of 18 per cent. Some of the poorest Arab countries have the highest rates of out-of-pocket payments in health, such as the Sudan at a 66 per cent share of current health expenditure. Egypt's share is 62 per cent.

Figure 40. Health-care indicators in low-income Arab countries by wealth quintile (Percentage)



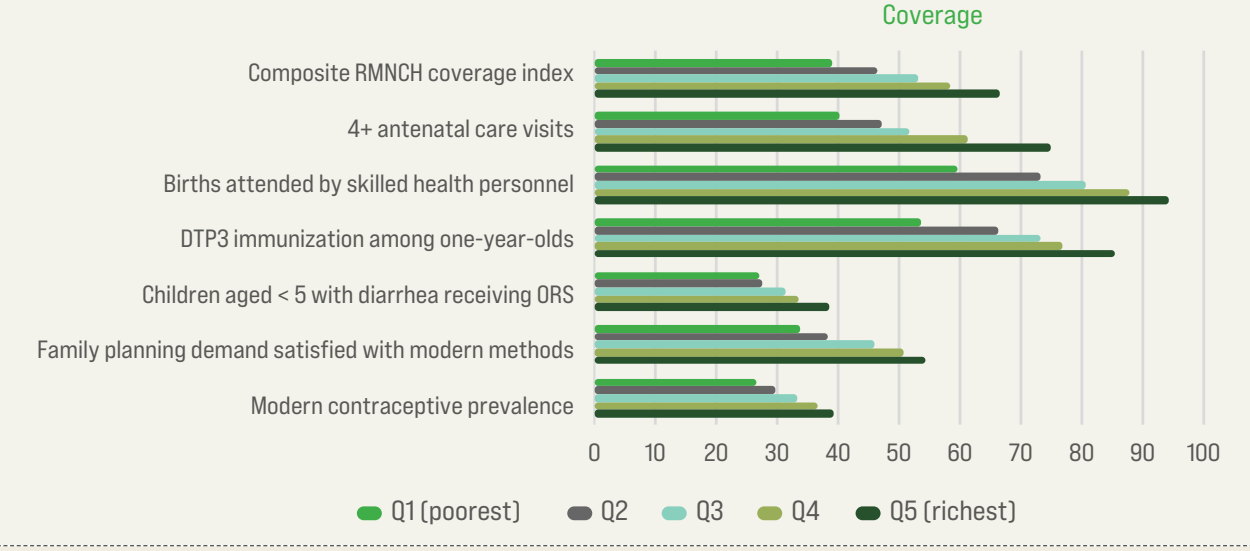
Source: WHO, n.d.b.

Figure 41. Health-care indicators in middle-income Arab countries by wealth quintile (Percentage)



Source: WHO, n.d.b.

Figure 42. Health-care indicators in Arab countries with fragile and conflict-affected situations by wealth quintile (Percentage)

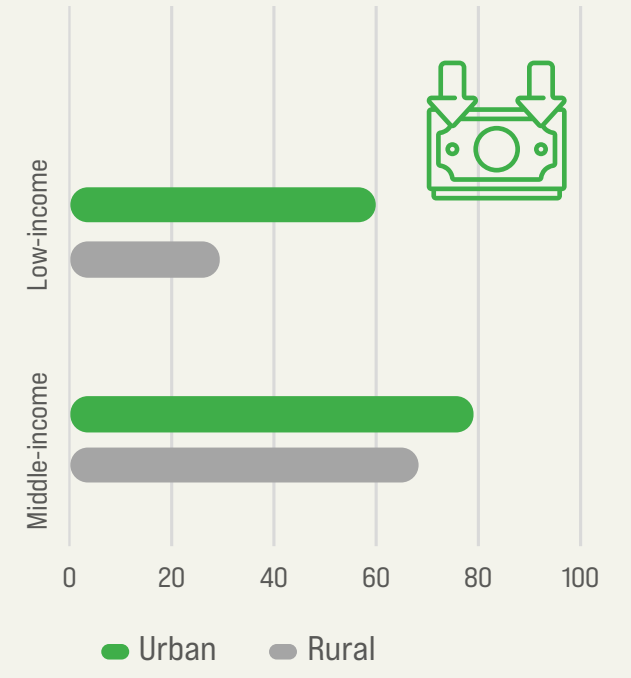


Source: WHO, n.d.b.

A composite reproductive, maternal, newborn, and child health index[115] finds access aligned with wealth in all three country types. Inequity between the richest and poorest groups is higher in low-income countries with a 35 percentage point coverage gap compared to a 9 percentage point gap in middle-income countries. In principle, wealthier countries are better equipped to meet per capita spending targets and more likely to achieve more equitable distribution in health care. Similar trends are seen in indicators of maternal health care in urban and rural areas. In low-income countries, antenatal care coverage is 30 percentage points higher for urban households. In middle-income countries, the gap is 11 percentage points (figure 43).

Figure 43. Antenatal care coverage of at least four visits (Percentage)

Rural-urban disparities in antenatal care emerge in all country types but are worse in low-income countries



Source: WHO, n.d.b.

Discrepancies in expenditure on different levels of education are readily apparent, intersecting with household income. Inequities in educational access according to wealth, as measured by the net attendance rate in figure 44, are lowest in children of primary age, since primary enrolment is near universal. Iraq is an exception with a 13 percentage point gap between the richest and poorest quintiles. Countries with the highest inequities in primary school enrolment – the Sudan and Yemen – are among the poorest in the region.

Inequities are far higher in early childhood education than at the primary level. Underinvestment in early childhood education has produced a situation where richer populations can afford to send their children to private schools while barely half of children in the poorest quintile are able to attend. This sets off a spiral of inequities where poorer children are less prepared for primary school. If they reach secondary school, they may run into a second drop-off in public investment at that level and be unable to complete their education. At that point, inequities begin to spill beyond education to the wider world as young people leave school, attempt to find employment and otherwise transition into adult life.

In social protection, data on benefit incidence[116] allow assessment of whether allocation decisions have improved or worsened equity. A lack of recent data limits analysis reflecting reforms,[117] but available data suggest that benefit incidence is inequitable in every country except Djibouti (figure 45). In most instances, benefits captured by the richest quintile are equal to or greater than those reaching the poorest quintile, likely due to the longstanding focus on subsidizing costly commodities used more by richer groups.[118] Egypt, Iraq, Jordan, the Sudan, and Tunisia have both benefit incidence data and SEM data. Among them, Jordan displays the lowest relative allocations to fuel and electricity subsidies and the most equitable targeting of social assistance to the poor. Iraq commits the highest share of social protection expenditure to fuel and electricity subsidies and has the lowest benefit incidence of social assistance for the poorest quintile. These trends indicate a potential relationship between allocative inefficiency in social assistance and fiscal inequity.

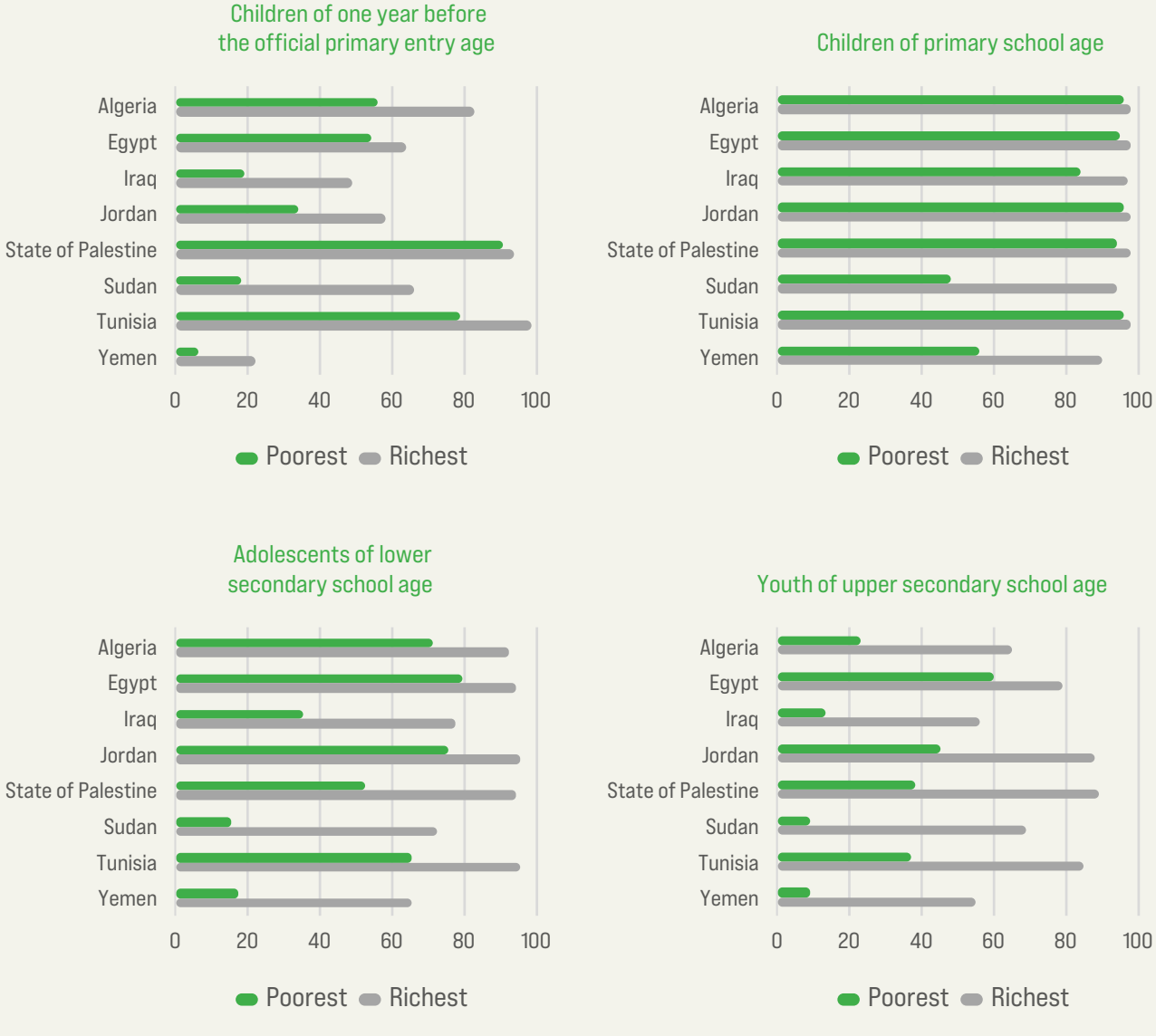
Inequities are far higher in early childhood education than at the primary level.

Disaggregation of the benefit incidence of different social assistance programmes shows similar patterns for most Arab countries, with some notable exceptions. The benefit incidence of cash transfers in Jordan suggests higher allocative efficiency, since the poorest quintile receives the most benefits, and benefits progressively fall for higher-income quintiles.

Djibouti and Jordan demonstrate moderately efficient allocations for social assistance and cash transfers (figure 46). But for in-kind transfers, it reverses to a pro-rich benefit incidence that stands as the most inefficient allocation among all the countries reviewed, beyond even Iraq, which is inefficient across cash and in-kind transfers.

Figure 44. Adjusted net attendance rate of the poorest and richest wealth quintiles (Percentage)

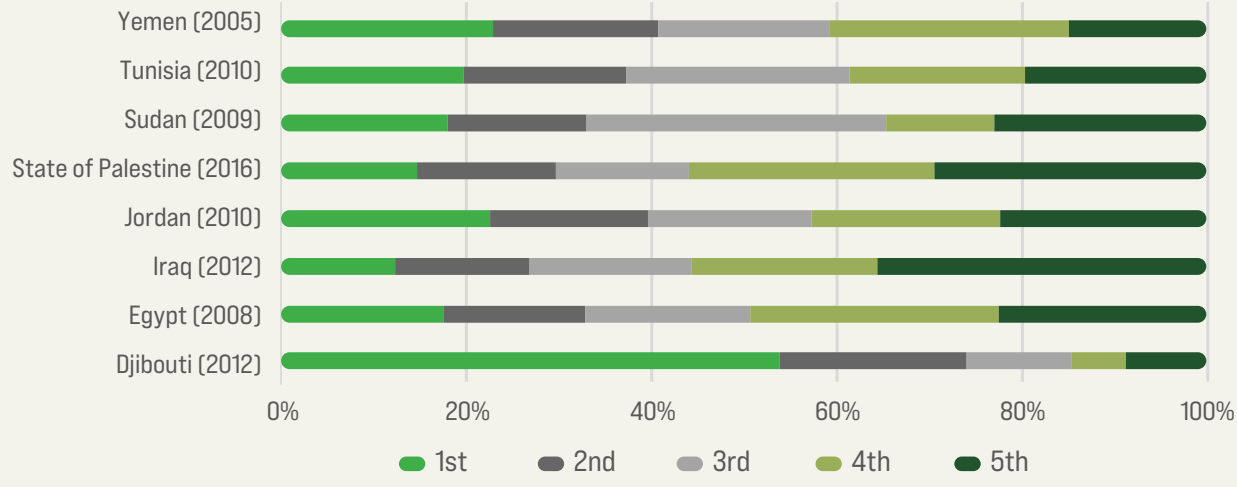
Net attendance rate differs across household income levels



Source: World Bank, n.d.c.

Figure 45. Benefit incidence of social assistance by quintile of income distribution

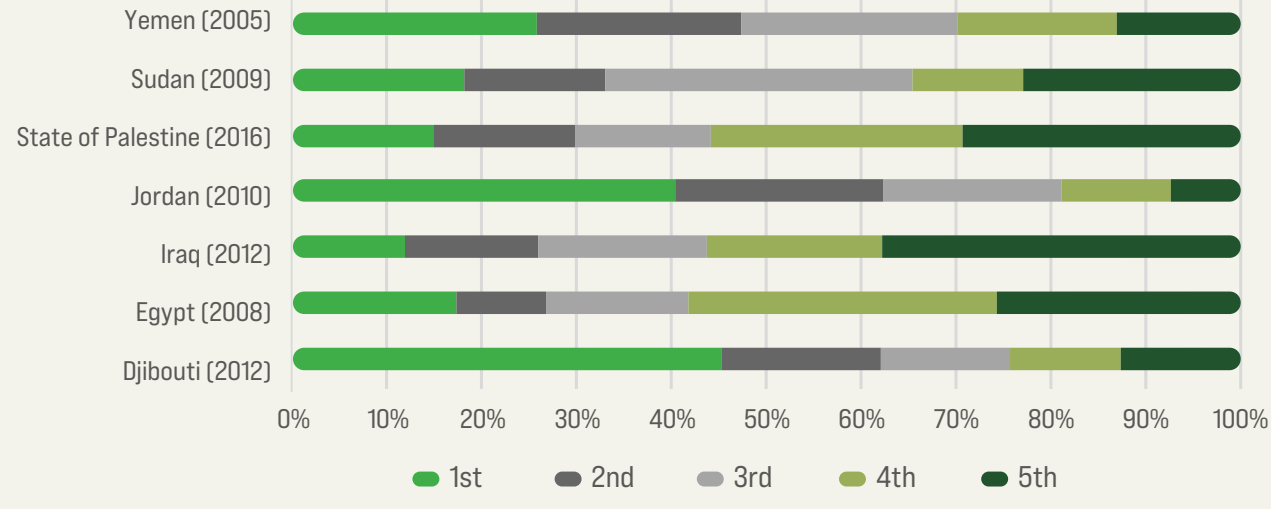
Social assistance benefit incidence is inequitable in almost every country



Source: World Bank, n.d.c.

Figure 46. Benefit incidence of cash transfers by quintile of income distribution

Cash transfer benefit incidence also tends to be inequitable, with some exceptions



Source: World Bank, n.d.d.

Another form of assistance entailed increased distribution of in-kind transfers to beneficiaries of existing cash transfer programmes, as in Iraq and Yemen (figure 47). In Djibouti, for example, such targeting may have improved equity. Nonetheless, this kind of horizontal expansion cannot be assumed to be wholly inefficient, given a crisis where large swathes of populations experienced falling incomes and living standards, and increased risks of poverty and vulnerability.

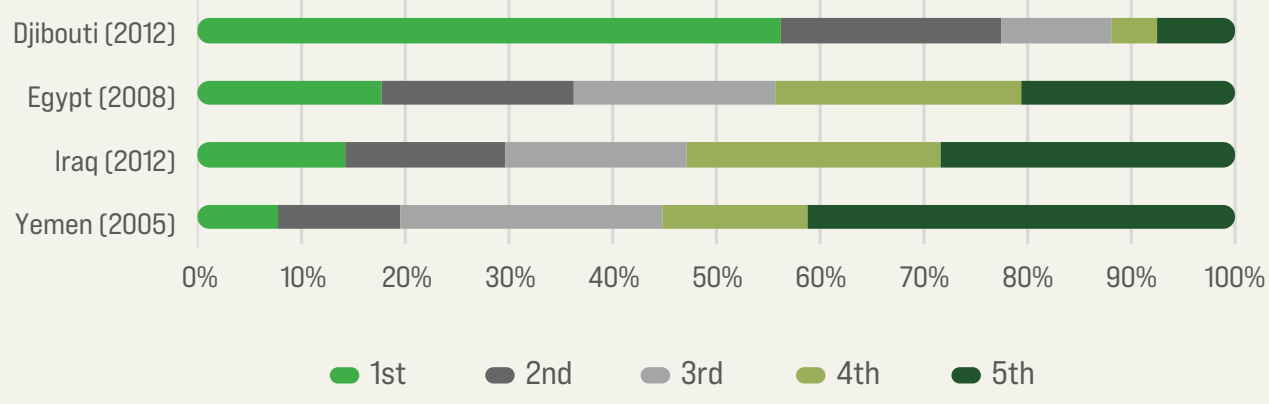
The inadequacy of targeting, however, was evident in the fact that every Arab country assessed showed a pro-rich trend in benefit incidence for social insurance.The steepest inequities were in Djibouti, Egypt and the State of Palestine where the

benefit incidences for the richest quintiles were 10 times (in Djibouti and Egypt), and 36 times (in the State of Palestine) greater than that for the poorest quintile (figure 48).

The COVID-19 pandemic fiscal stimulus packages changed social spending in the Arab world, with the most profound shifts involving increased investment in and the changing nature of social protection. Most Arab States announced a range of social protection measures covering social assistance, social insurance, loans and tax benefits, and labour market support.[119] Among 200 COVID-19 social protection responses in the region, unconditional cash transfers, recognized as a pro-poor mechanism, have been the most common single intervention, with 16 countries adopting them.[120] While in-kind vouchers ranked as the second most common policy measure globally, the Arab region relied more on waivers of utility bills.

Figure 47. Benefit incidence of in-kind transfers by quintile of income distribution

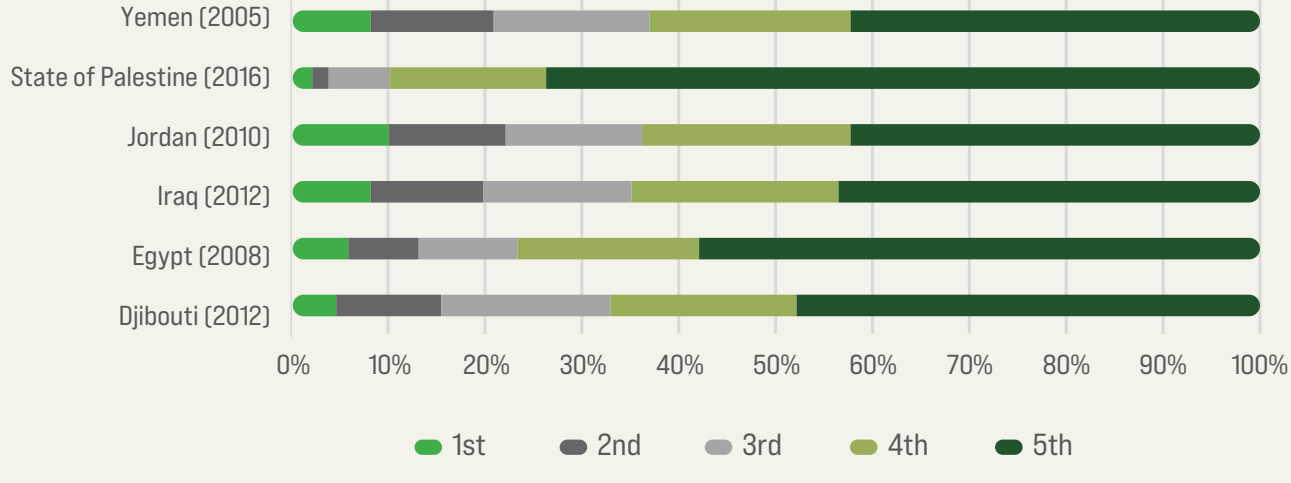
In-kind transfers tend to be inequitable, with some exceptions



Source: World Bank, n.d.d.

Figure 48. Benefit incidence of all social insurance by quintile of income distribution

Social insurance was pro-rich in the benefit incidence in almost every country



Source: World Bank, n.d.d.

Most countries announced initiatives to provide temporary income to households and individuals who became vulnerable during the pandemic. The overall adequacy of these efforts has been a concern for vulnerable populations, however, given a low amount of fiscal stimulus. Just 11 per cent of stimulus packages in the region targeted people through social protection and health measures.[121] The equity impact of in-kind transfers depended on targeting. Nine Arab countries provided food baskets and hygiene materials for vulnerable families, likely improving equity.[122]

The expansion of existing social insurance schemes and the introduction of new ones in response to the pandemic had potentially positive implications for equity in access. Four Arab countries provided additional health insurance, 16 offered leave benefits and 10 provided unemployment insurance and/or wage subsidies.[123] Morocco allowed the renewal of health insurance for those made redundant due to the crisis, targeting a subpopulation with newly increased vulnerability. Across countries, the most common measures targeted people working in non-essential public services and those belonging to social insurance organizations.

Despite the nature of the crisis, not all countries pursued policy measures related to health insurance or extended coverage. The Sudan did extend coverage; Saudi Arabia renewed health insurance for families for free. Egypt has provided COVID-19 related treatment without any user fees to ensure equity and quality in service delivery for all.[124] But in general, inequitable access to health services made the impacts of COVID-19 highly unequal. Waiving fees and subsidizing health insurance are two fundamental measures to ensure that the poorest and most vulnerable people can access health care.

At a regional level, 57 per cent of additional social assistance measures were aimed at employees and self-employed persons, while 12 per cent targeted specific vulnerable populations and 8.5 per cent were intended for the unemployed. The last two categories will likely contribute to equity or at least constrain further inequities as a result of the pandemic. It is unclear how programmes aimed at employed or self-employed persons will impact equity. Reaching self-employed persons in the informal sector would likely mitigate inequity. In Egypt, informal workers who registered with the Ministry of Manpower gained access to unemployment benefits as did workers who became temporarily unemployed in Tunisia.

Most policy measures targeted individuals and families but it is less clear how consistently they benefited the poorest and most vulnerable people. Many countries stumbled in implementing social insurance policies given their lack of preparedness. This was especially the case for informal workers, where Governments resorted to social assistance rather than social insurance. In some cases, cash aid was extended to unemployed informal sector workers at a rate far lower than the minimum wage.

Some new cash transfer schemes targeted marginalized individuals and groups, such as informal sector workers in Morocco, persons with disability and homeless people in Tunisia, and women aged 65 and above in nursing homes under the umbrella of social protection for elderly women in Egypt. In Morocco, households with non-contributory health insurance received a mobile payment of 800-1,200 Moroccan dirham ($80-120), depending on household composition. In the State of Palestine, the Ministry of Labour provided cash assistance to COVID-19-affected workers as a temporary form of unemployment support.

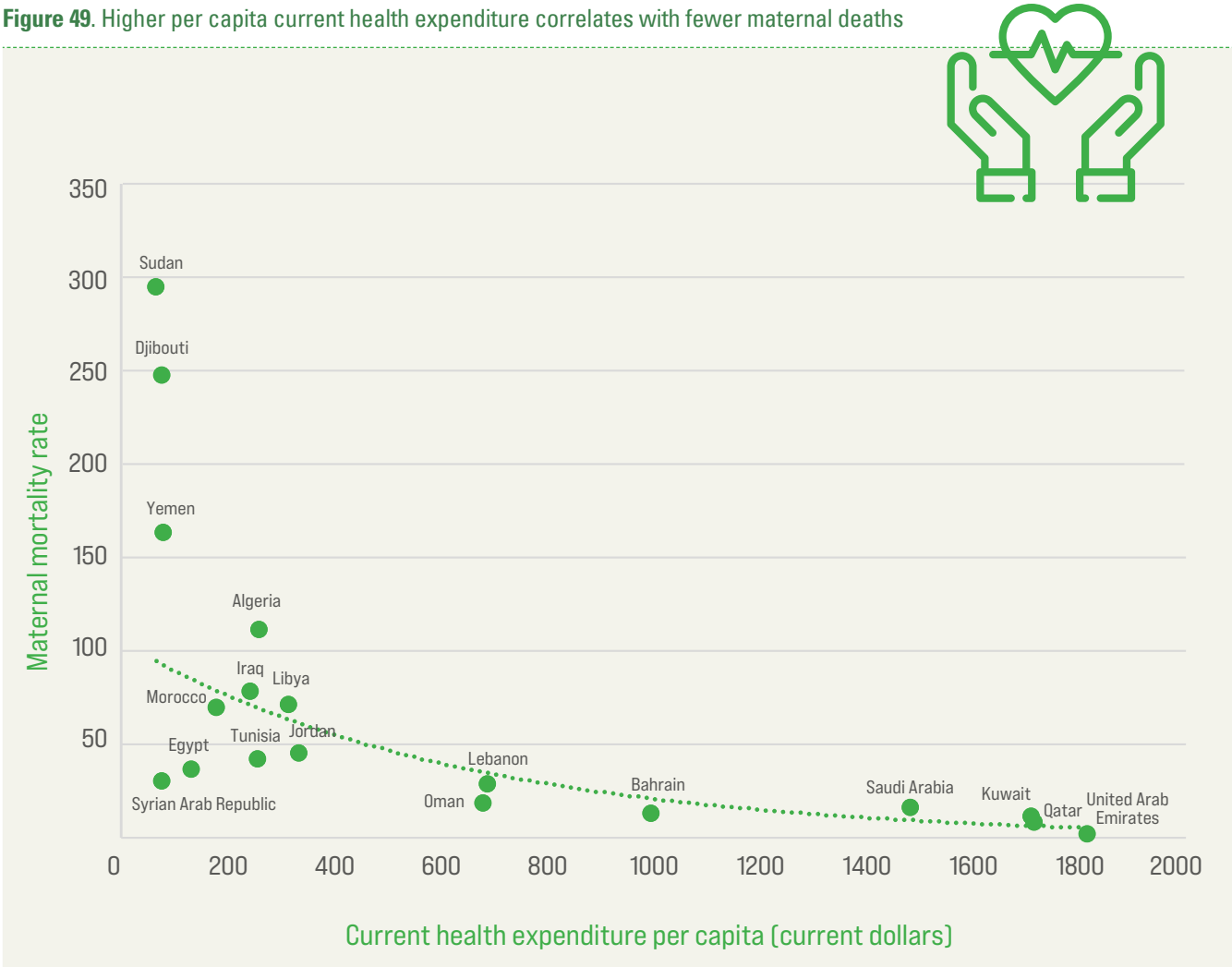
Several policy measures sought to reach female-headed households and women employees. Bahrain, Egypt, the Sudan, and the United Arab Emirates provided paid leave or work from home options for women employees to take care of their families. Care services were enhanced through cash transfer mechanisms in Mauritania, where a national solidary fund provided $135 million to 30,000 households headed by women and other vulnerable populations.

C. Fair or unfair, spending defines development outcomes

Another perspective on equity in public financing considers the results of investment, measured by key indicators of health, education and social protection. This highlights how skewed financing reinforces social and economic inequities, and prevents the realization of basic rights for the poorest and most vulnerable populations. Comparing current health expenditure with maternal mortality shows a correlation between higher expenditure and fewer deaths in Arab countries, for example (figure 49).

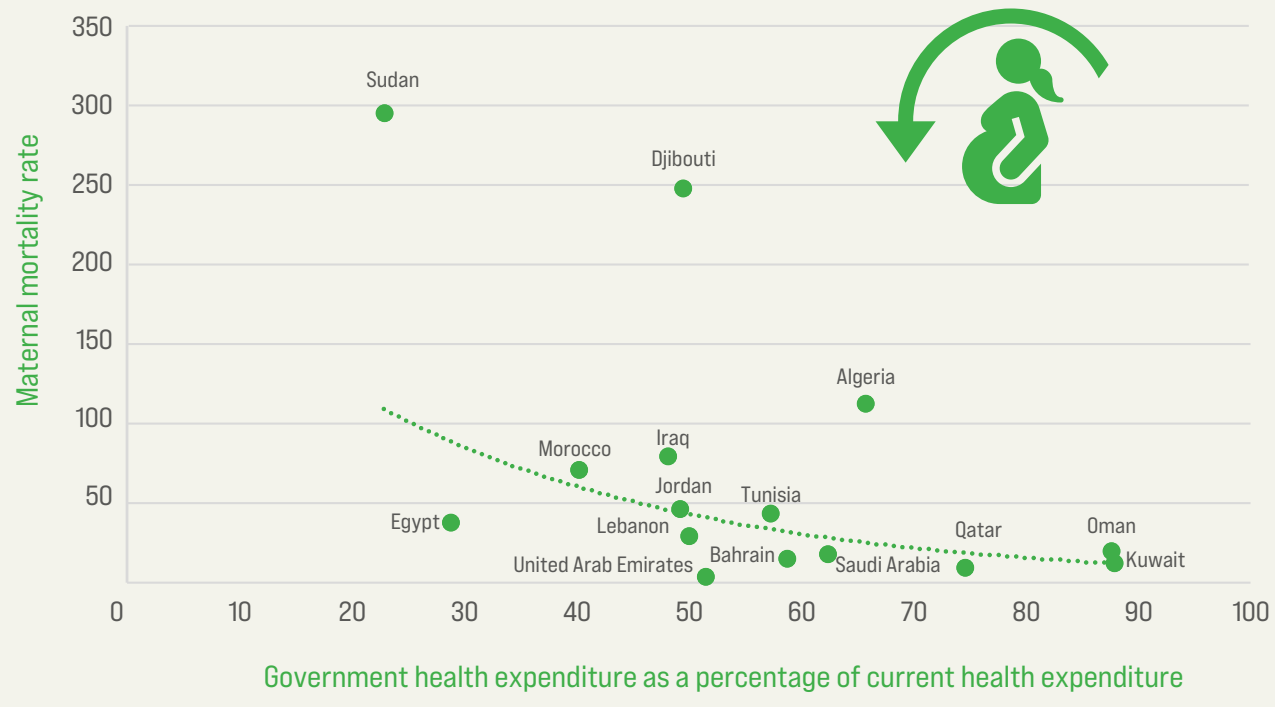
There is also an association between maternal mortality and sources of funds. Arab countries with higher Government health expenditure as a proportion of all health expenditure tend to have fewer deaths (figure 50). Higher out-of-pocket spending as a share of current health expenditures also results in higher rates of maternal mortality (figure 51). In short, countries with the best maternal outcomes spend more per capita on health, draw a significant proportion of at least 50 per cent of financing from Government public expenditure and maintain low levels of out-of-pocket spending.

Figure 49. Higher per capita current health expenditure correlates with fewer maternal deaths



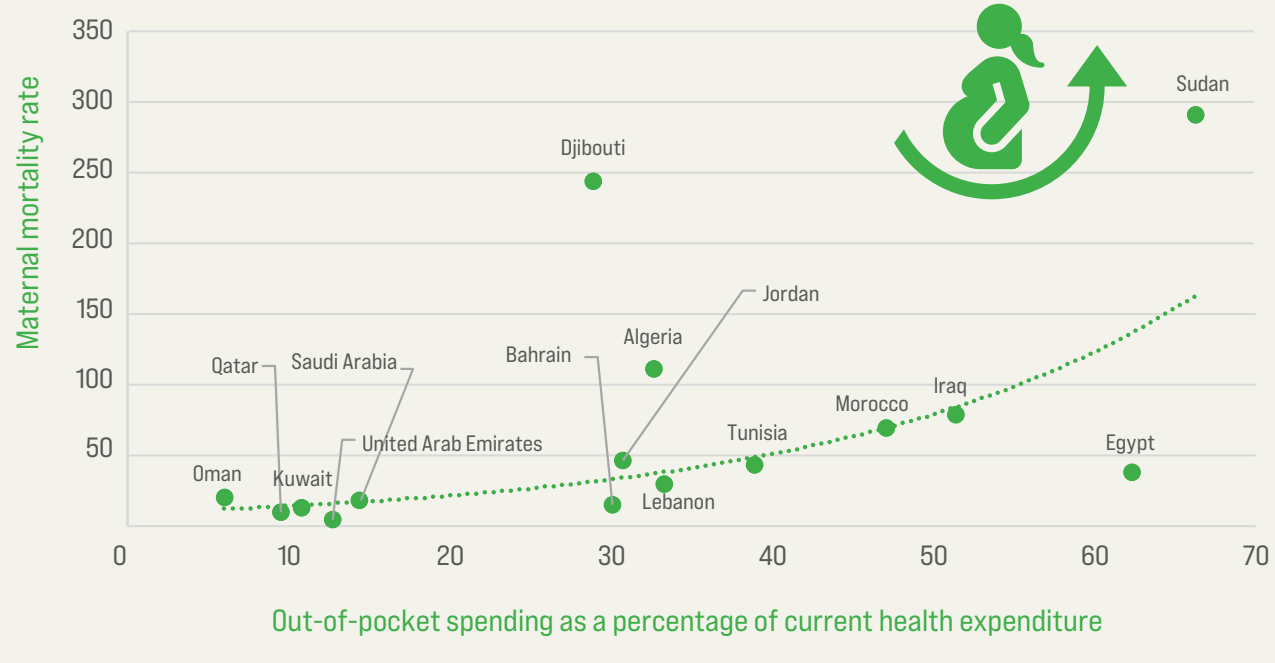
Source: World Bank, n.d.c.

Figure 50. Where Government expenditure is a greater share of total health spending, maternal deaths decline



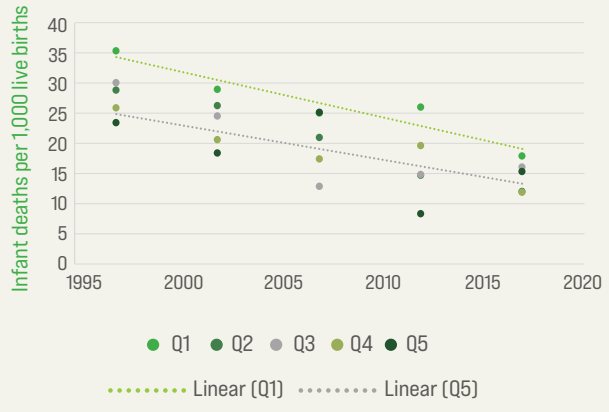
Source: World Bank, n.d.c.

Figure 51. When people spend more from their own pockets, maternal deaths rise



Source: World Bank, n.d.c.

Figure 52. In Jordan, higher infant mortality rates in poorer communities reflect gaps in essential health care



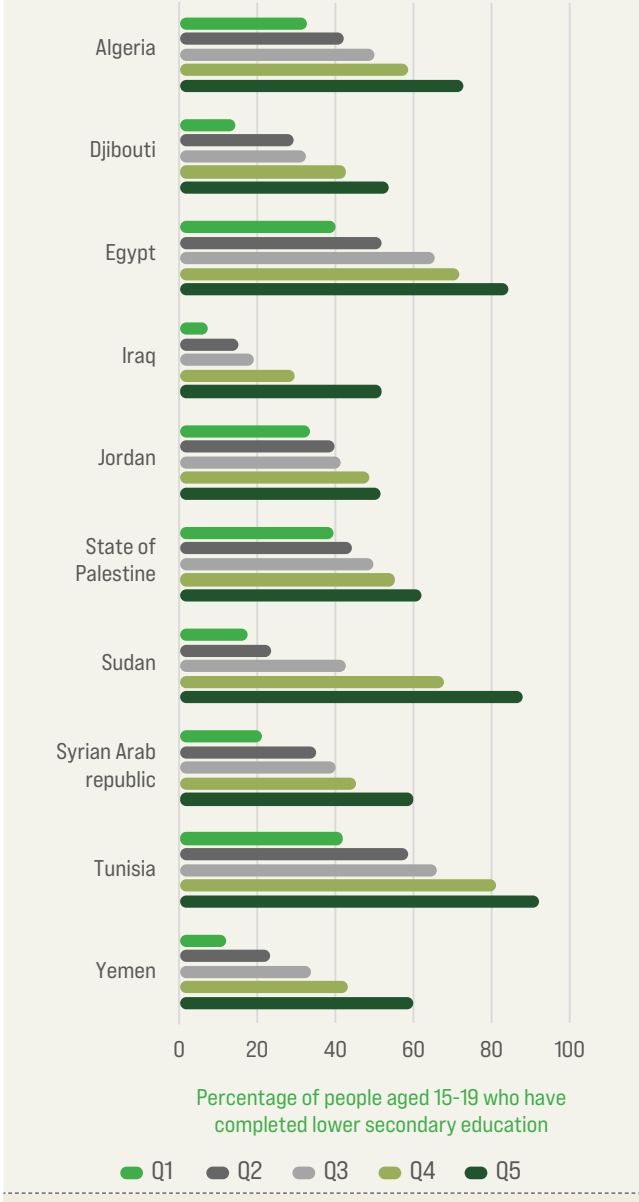
Source: WHO, n.d.c

Note: Data from 1997, 2002, 2007, 2012 and 2017.

While health financing structures determine outcomes at a national level, they also affect different groups unevenly. Disaggregating data by income quintile, sex or geographic location reveals disparate outcomes. In Jordan, poorer populations suffer more from infant mortality than their richer counterparts. While recent years have seen declining inequalities among wealth quintiles, infant mortality is highly sensitive to life-saving service provision so remaining gaps indicate that poorer groups still face greater barriers to essential health care. These obstacles might not all be financial; geographic, administrative or psychosocial issues may also be in play. Health financing that is adequate and well targeted, however, generally mitigates at least some of these disparities (figure 52).

Similar issues are at work in education, where gains are hindered by inequity in financing. Over the past decade, expected years of schooling in the Arab region increased by 0.458 years and harmonized test scores improved by 0.443.[125] These advances have not been universal, however. Without sufficient public expenditures to correct disparities resulting from income, students in the wealthiest quintile often score close to advanced international benchmarks in literacy and numeracy.[126] The poorest students have yet to achieve even the lowest international standards.

Figure 53. Poorer people in low-income countries and those with fragile and conflict-affected situations have the lowest secondary school completion rates (Percentage)



Source: World Bank, n.d.c.

Critically, inequality in lower secondary completion rates becomes more pronounced in low-income States with constrained fiscal space. Some of the poorest educational outcomes are in countries with fragile and conflict-affected situations (figure 53). In 2017, 3.5 million children were out of school in the Sudan, the Syrian Arab Republic and Yemen,[127] where conflicts reduced social spending, suppressed economic growth and diminished Government capabilities to collect taxes.

Social protection outcomes, represented by the poverty headcount rate, are also associated with social spending. Where public spending on social protection as a proportion of GDP is higher, poverty tends to be lower, at poverty headcount rates of $3.20 per day (figure 54). This association would likely be even stronger when considering the share of spending that benefits the poorest in society. In Egypt, for example, social protection spending is high, but since benefits flow disproportionately to the rich, the impacts are muted in terms of achieving lower poverty rates (figure 55).

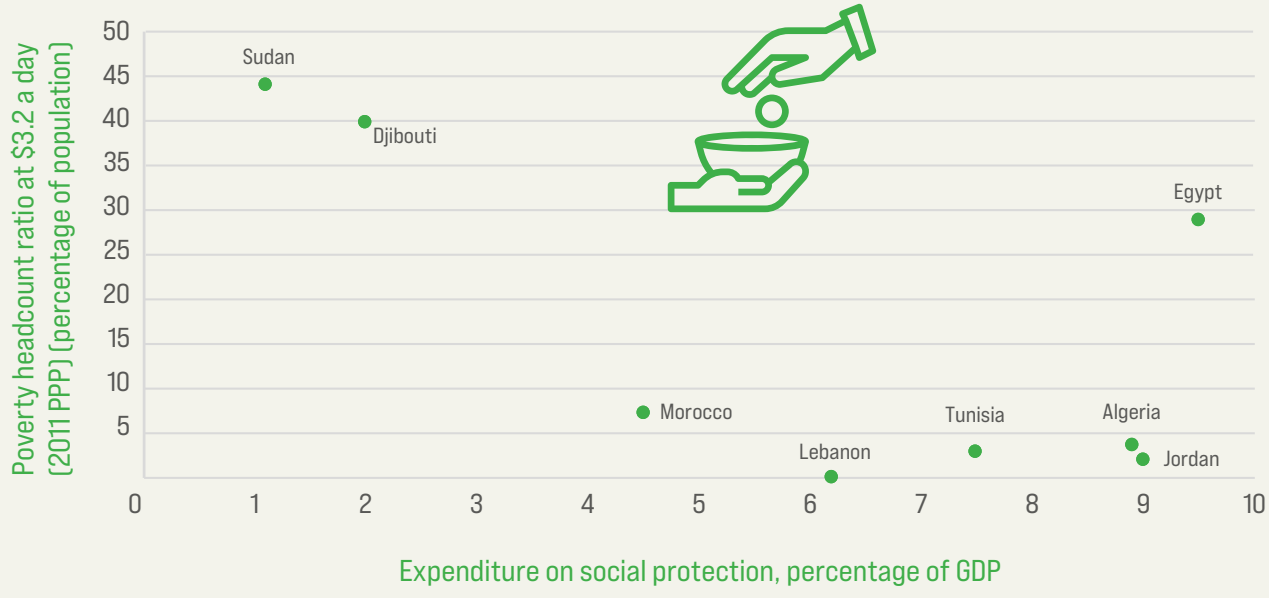
The COVID-19 pandemic fiscal stimulus packages changed social spending in the Arab world.

Figure 54. Greater spending on social protection is associated with lower poverty headcount rates

Source: ILO, 2021; World Bank, n.d.e.

Note: Data are as of 2017 or the most recent available.

Figure 55. Spending on social protection as a proportion of GDP compared to the poverty headcount rate in Arab countries with available data (Percentage)



Source: World Bank, n.d.e.

Note: Data are as of 2017 or the most recent available.

D. Rethink and reform for improving equity, lessening inequality

Tackling inequity inherently requires new political choices. Across the Arab region, equity has not historically been at the forefront of decision-making, which explains regressive policy choices reflected in disparities in access to essential social services. Inequities in sourcing, allocating and spending public funds compound shortfalls that sustain deeply rooted development deficits for the most vulnerable populations.

The economic shocks triggered by COVID-19 have laid bare how these are disproportionately born by more vulnerable households, and that existing social protection, health and education systems are not necessarily equipped to mitigate fallout for those in most need. A torn safety net meant that 16 million additional people in the region were expected to fall into monetary poverty in 2021 due to the pandemic; half would be children.[128] Inequitable financing for social services means they also face the longest road to recovery. Pre-existing trends of privatization in health and education, high out-of-pocket spending and flawed targeting mechanisms are prime concerns. Mounting pressures now come from contracting economic growth and high debt burdens, which could force sharp cuts in public social expenditure. This would be catastrophic in terms of equity, hopes to achieve the SDGs and the realization of human rights.

It is now more important than ever to redress inequities in the allocation and spending of public funds, between and within sectors,

across population groups and in light of development goals. The urgency of the need to strengthen social protection systems and protect the most vulnerable in society is further underlined by the expectation that future economic shocks will be more frequent in the era of climate change, with projections for the most of Arab region showing higher increase in temperatures than the global average.[129]

Better understanding of the value of fiscal equity should prompt a rethink leading to reforms that put equity and the universal realization of rights at the forefront of policy design. Fiscal equity reinforces other core principles such as budgetary adequacy, efficiency and effectiveness. It implies prioritizing adequate allocations, in absolute and proportionate terms, to social sectors and ensuring that budgets are financing services most important to the poorest and most vulnerable populations. Such efforts may be initially controversial but could form the backbone of a new social contract built on justice and human well-being.

Endnotes

76 Alvaredo, Assouad and Piketty, 2018a. This paper finds that the Middle East and North Africa region is the most unequal region in the world when top income deciles are used to analyse income inequality both within and between countries.
77 ESCWA, 2019a.
78 Malik, 2016.
79 Malik, 2014.
80 UNDP, 2011; ESCWA, 2014a.
81 ESCWA, 2014d.
82 ESCWA, 2014a.
83 Drummond, 1989.
84 McIntyre, Meheus and Røttingen, 2017; WHO, 2014.
85 McIntyre, Meheus and Røttingen, 2017.
86 UNESCO, 2015.
87 ILO, n.d.b. This calculation applied the World Bank definition of world regions.
88 Chetty and others, 2016.
89 WHO, n.d.a. The global data set on primary health-care expenditure as a percentage of Government health expenditure includes 65 countries.
90 Stenberg and others, 2019.
91 Authors' calculations, drawing on country projections in Stenberg and others, 2019.
92 Heckman, 2017; 2008.
93 Gertler and others, 2014.
94 UNESCO, 2021.
95 Hatim, 2020; El Attaq, 2021.
96 World Bank, n.d.a.
97 Popova, 2021.
98 Ibid. Calculated by authors at $1.90 per day.
99 Ibid.
100 IMF, 2020a.
101 ESCWA, 2013a; UNDP, 2021a.
102 Jawad, 2015.
103 ESCWA, 2013a.
104 Ibid.
105 Cockburn and others, 2014.
106 Talaat, 2018.
107 Central Agency for Public Mobilization and Statistics (CAPMAS), 2020.
108 Talaat, 2018.
109 Verme and Araar (eds.), 2017.
110 Megersa, 2020.
111 UNDP, 2021a.
112 ESCWA, 2013a.
113 This draws on health data from household surveys conducted in Algeria (2018), Egypt (2014), Iraq (2018), Jordan (2017), the State of Palestine (2018), the Sudan (2014), Tunisia (2018), and Yemen (2013). Classification of country groups: Low-income countries with fragile and conflict-affected situations include: the Syrian Arab Republic, the Sudan and Yemen. Fragile and conflicted-affected situations include Iraq, the State of Palestine, the Sudan, the Syrian Arab Republic, and Yemen. Middle-income countries include Algeria, Egypt, Jordan, and Tunisia.
114 Hill and others, 2014.
115 The composite coverage index is a weighted score reflecting coverage of eight interventions along the continuum of care, as follows: demand for family planning satisfied (modern methods); antenatal care coverage (at least four visits); births attended by skilled health personnel; BCG immunization coverage among 1-year-olds; measles immunization coverage among one-year-olds; DTP3 immunization coverage among 1-year-olds; children aged less than 5 years with diarrhoea receiving oral rehydration therapy and continued feeding; and children aged less than 5 years with pneumonia symptoms taken to a health facility.
116 The OECD glossary of statistical terms defines benefit incidence analysis as computing the distribution of public expenditure across different demographic groups. The procedure involves allocating per unit public subsidies according to individual utilization rates of public services. Such analysis usually relates to public expenditure and is concerned with how effectively Governments target limited resources to meeting the needs of the poor.
117 The data in this section fail to account for social assistance reforms in some countries. For example, since the benefit incidence analysis in Egypt in 2008, the country has introduced two major cash grant programmes, Takaful and Karama, which directly target the poorest two quintiles.
118 Silva, Levin and Morgandi, 2013.
119 As mapped by the COVID-19 Stimulus Tracker (United Nations, n.d.).
120 United Nations Issue-based Coalition on Social Protection, 2020.
121 Ibid.
122 World Bank, n.d.d.
123 United Nations, n.d.
124 Duran and Menon, 2020.
125 World Bank, 2021e.
126 UNICEF Middle East and North Africa Office (MENARO), 2015.
127 UNICEF MENARO and International Policy Centre for Inclusive Growth (IPC-IG), 2018.
128 Abu-Ismail, K., 2020.
129 ESCWA and others, 2017.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