

Political Context, Organizational Mission, and the Quality of Social Services: Insights from the Health Sector in Lebanon

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Summary. — Non-state actors are important providers of social welfare. In parts of the Middle East, South Asia, sub-Saharan Africa, and other regions, religious charities and parties and NGOs have taken on this role, with some preceding independent statehood and others building parallel or alternative welfare infrastructure alongside the modern state. How well do these groups provide welfare goods? Do some exhibit a “welfare advantage,” or a demonstrated superiority in the quality and efficiency of providing social services? In this paper, we explore whether distinct organizational types are associated with different levels of the quality of care. Based on a study in Greater Beirut, Lebanon, where diverse types of providers operate health centers, we propose and test some hypotheses about why certain organizations might deliver better services. The data indicate that secular NGOs, rather than religious, political or public sector providers, the other main types of providers in the charitable sector, exhibit superior measures of health care quality, particularly with respect to objective provider competence and subjective measures of patient satisfaction. In Lebanon, where religious and sectarian actors dominate politics and the welfare regime and command the most extensive resources, this appears to be a counterintuitive finding. Our preliminary explanation for this outcome emphasizes the ways in which the socio-political context shapes the choices of more qualified or professional doctors to select into secular providers, in part because of their organizational missions, and why citizens might perceive these providers to be better, irrespective of the actual quality of services delivered.

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1. INTRODUCTION

In many developing countries, non-state actors are important providers of social welfare, with some preceding independent statehood and others building parallel or alternative welfare infrastructure alongside the modern state. A wide array of actors, including NGOs, religious charities, and even political parties, are in the business of providing health services, schooling, vocational training, and other important services, and thus greatly affect the standards of living and well-being of low- and middle-income people (Cammett & MacLean, 2014). Yet little research explores the quality of welfare goods supplied by non-state providers (NSPs). Do certain types exhibit a “welfare advantage,” or a demonstrated superiority in the quality of social service provision?

In this article, we propose and assess a variety of hypotheses related to organizational type and the quality of services and develop some propositions about the effects of organizational mission on service delivery. Based on evidence from an original set of surveys in primary health centers affiliated with diverse public and non-state actors in Greater Beirut, Lebanon, we show that secular NGOs demonstrate an apparent welfare advantage over other provider types in both objective and subjective measures of health quality.¹ Further, patient evaluations of health centers run by distinct organizations are driven largely by perceptions of doctors, and doctors who work in secular organizations report higher levels of satisfaction with the organizations where they work. This apparent *secular* welfare advantage contradicts many theoretical and empirical expectations, as we detail below. Our proposed explanation for this result centers on the ways in which the political context affects both the objective and subjective quality of care by secular, religious, and political groups through supply and demand processes. In a polity structured explicitly along religious lines, being an avowed secularist goes against dominant social and political trends and offers few if any

material rewards because such groups do not have access to the resources needed to run patronage networks, which are associated with more politically connected religious and sectarian organizations. As a result, secular NGOs that provide health services may attract doctors who are more inspired by intrinsic motivations, such as charitable considerations or a commitment to professionalism. Second, widespread citizen dissatisfaction with religious and sectarian organizations,² which are often viewed as corrupt and self-serving in polities where they are involved in national politics, may result in inferior evaluations of welfare programs run by these types of groups and, conversely, more favorable assessments of services provided by organizations that explicitly dissociate themselves from political sectarianism.

In the next section, we justify our focus on the health sector, present a multidimensional definition of “quality” in primary health care, and review arguments about why some types of

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providers may be especially adept at providing health care and other types of social services. The third section of the paper provides essential background information on Lebanon and on the types of organizations in question and describes the data and key variables used in the analyses. Section four presents descriptive and statistical analyses followed by a discussion of the implications of the findings for the relationships between organizational mission, political context, and the quality of service delivery. In the conclusion, we summarize the findings and suggest a broader research agenda on political context, organizational mission, and the quality of service delivery.

2. POLITICS, HEALTH, AND DIMENSIONS OF HEALTH CARE QUALITY

For a variety of reasons, social scientists—and not just public health and medical specialists—should be concerned with the politics of health, and the health sector is an appropriate arena for examining whether different types of organizations exhibit a welfare advantage. First, because many NSPs are involved in the delivery of medical services (Cammatt, 2014; Thachil, 2014) and access to health care is important to well-being, people may feel indebted to institutions that provide or mediate access to medical services. Second, cognizant of these potential payoffs, political organizations face incentives to deliver or claim credit for the provision of health care. Third, the health system is a critical locus of citizen interactions with governments, which play an important role in the financing and provision of health care in middle-income countries (Rockers, Kruk, & Laugesen, 2012) and with non-state providers, which are either well established or increasingly important in welfare regimes in developing countries (Cammatt & MacLean, 2014; Wood & Gough, 2006). Finally, in societies with politicized ethno-religious identities, as in Lebanon, the provision of basic services also helps to constitute a sense of group membership by establishing boundaries of inclusion and exclusion in political communities (Cammatt, 2014). Thus, the provision of health care intersects with politics in both direct and indirect ways.

(a) *Measuring health care quality*

In the literature on health policy and management, it is widely accepted that quality encompasses multiple dimensions, including objective and subjective measures as well as technical and non-technical factors. In broad terms, health care quality includes three components related to the structure, process, and outcome of the delivery of health services, respectively (Donabedian, 1988; Klassen et al., 2010). The structural dimension of quality refers to the environment in which health care is provided, or the material and human resources and characteristics of the facility where services are delivered as well as the organization of the delivery of medical services. This includes the availability and condition of medical equipment and trained medical staff, medications, and relevant infrastructure as well as the ways in which physical and human resources are managed up and down the supply chain in the delivery of care. The process-oriented component of quality addresses the method by which health care is provided, focusing in particular on the ways in which providers interact with patients as well as provider capabilities and effort. Process measures assess doctor knowledge and training as well as the degree to which they apply this knowledge to deliver appropriate care to patients in a timely and respectful manner.

Finally, outcomes denote the results of health care, notably the health status of patients and patient satisfaction, among other factors (Stelfox & Straus, 2013; Tuan, Dung, Neu, & Dibley, 2005).

Two points related to the conceptualization and measurement of health care quality should be emphasized and guide our choice of indicators. First, health outcomes result from a variety of factors above and beyond the delivery of services (Wilkinson & Marmot, 2003), complicating efforts to link them definitively to the provision of medical care. As a result, our analyses do not aim to explain health outcomes. Second, public health research shows that the process dimensions outweigh the structural aspects of quality in affecting health outcomes (Das & Hammer, 2014). A doctor who is well-trained, regularly shows up to work, and practices medicine at their “knowledge frontier” has a greater impact on patient health than the mere availability of medical supplies and new machines. Without capable and committed professional staff, state-of-the-art medical equipment has little effect on patient health. Likewise, patients are more likely to report more favorable views of their service providers when they seem competent, engaged, and attentive, even when the facility in which the care is provided is less attractive and less well appointed. Thus, while we account for the structural dimensions of quality in our analyses, we focus most centrally on process quality. Furthermore, most of statistical analyses aim to explain subjective measures of quality, notably patient satisfaction, because *perceptions* of performance rather than objective measures of quality are more germane to citizen evaluations of providers and, therefore, are likely to have a more direct impact on political attitudes and preferences (Cammatt, Lynch, & Bilev, 2015; Christensen & Læg Reid, 2005). Indeed, our hypotheses, which highlight the reasons why competent doctors select into some provider organization and why some patients report more favorable views of some provider types, are more directly relevant to the process-oriented dimensions of medical care.

3. ORGANIZATIONAL MISSION AND THE QUALITY OF SERVICE DELIVERY

Distinct social science approaches, which we review briefly below, either directly or indirectly suggest that different types of organizations are likely to exhibit a welfare advantage (or disadvantage).

(a) *Faith-based organizations and charitable motivations*

A substantial literature on faith-based organizations (FBOs) holds that the charitable dimensions of religion motivate the pious to volunteer or work for minimal compensation to do social good (Clarke, Jennings, & Shaw, 2007; Cnaan & Boddie, 2002; DeHaven, Hunter, Wilder, Walton, & Berry, 2004; Unruh & Sider, 2005; Wuthnow, 2004). These approaches hold that religious organizations tend to attract personnel who are committed to their missions on spiritual grounds, making them willing to put in long hours, often for relatively minimal compensation. In addition, staff members and volunteers in religious charities may choose to serve others to ensure the survival of the congregation through income-generating activities or to foster acceptance of the religious group in the community where it is based. Social service provision may also aid in proselytism, a potentially powerful incentive for the leadership and staff of religious organizations to offer high-quality services and one that is relatively unique

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