What About the Refugees? Regime Type, Non-Selectorate Actors, and Health Policy

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***Abstract**: In order to tackle the question of refugee health care provision in relation to regime type, a three step approach was taken. First, regime type was shown to significantly influence various public health indicators; democracies increased health care quality due to constraints placed on the leader to appeal to constituents' health care interests. Next, citizens under authoritarian regimes with democratic institutions were determined to receive better health care because of effective citizen lobbying for their own interests as well as constraints on the autocratic leaders to appeal to their larger constituency. Finally, while employing the selectorate theory of social goods provision, the effect of regime type on refugee health care quality was determined. Citizen lobbying for their own health care interests becomes detrimental to refugee interests; thus, more authoritarian regimes possess greater freedom to provide better health care to refugees than less authoritarian host countries.*

Introduction:

Health—both mental and physical—can paint the intensity of an individual's societal and personal life in brilliant, colorful shades or dull, monotonous colors. Like the engine of a car, good health is often taken for granted until the moment it is taken away, or malfunctions. The goal, it would seem then, would be providing the maximum quality healthcare to the greatest number of people. To be sure, effective healthcare possesses a substantial scientific and technological component. However, the distribution of health care facilities, the education of health care professionals, the provision of a suitable infrastructure, and the enforcement of proper medical standards under times of peace and conflict are all intimately intertwined with the field of politics. The philosopher John Locke defined natural law as our right to protect "life, liberty, and possessions." So how do we, as political scientists, best protect our right to a long, healthy life?

The quality of provision and access to health care varies widely from country to country, regime to regime. Current political science literature accounts for this difference by emphasizing the variation in terms of regime type across various countries and time periods. The reasoning follows that a democratic country will provide a significantly better quality of health care for its citizens because of the greater political and civil freedoms afforded as well as the constraints that entail catering to a larger constituency. Authoritarian countries, which by their very nature do not face such large constituent constraints, will be less inclined to provide beyond the necessary baseline level of health care to its citizens. Refugees, however, are not significant actors in the interplay of electing a regime leader. Yet these individuals are still worthy of the right to a healthy life, and are often *more* in need of proper health care provision than regular citizens due to the loss of property, monetary possessions and political rights, the mental anguish, and the

dangerous and often fatal environments characteristic of the political refugee experience. Thus, does the particular regime type of the host country a refugee flees to and resides in affect the quality of healthcare she will be provided? According to previous research concerning the *citizens* of different regime types, the answer is a resounding "Yes." However, precisely because of the constraints placed on democratic regimes to focus the provision of broad public goods such as health care toward its *citizens*, non-citizen groups such as refugees will subsequently receive better health care under authoritarian regimes. Autocratic leaders possess greater decision-making freedom in regards to distribution of both public and private goods to particular segments of its population, including refugees such as in the Palestinian case study. The Palestinian refugee situation is particularly interesting because of its longevity and concentration to a specific region, lending itself to pronounced health care effects and available data. Furthermore, this variation in the quality of health care provision provided extends to variation *within* particular regime types—when "democracy" is measured on a sliding scale, refugees will generally receive progressively worse or better health care.

Part I: Does Democracy Matter?

Theory:

Democracy possesses its fair share of success stories—one only need look at the economic records and health indicators of most Western European countries or, for a more archetypal example, the United States. But are these accomplishments merely flukes caused by some lurking variable or is there something inherently "good" within the democratic model that paves the road to such success? According to previous research the latter appears to be the case: democratic regimes consistently provide better quality health care to their citizens than

authoritarian regimes because citizens in democracies can lobby for their own interests. Democratically elected leaders will subsequently provide broad societal goods, such as health care, to appeal to their larger constituencies.

This theory is corroborated by numerous studies—affirming the power of citizens in democracies to realize their policy preferences in the face of conflicting refugee interests or other fiscal priorities. A study of 17 Latin American countries from 1980 to 1992 suggested that during economic crises, democracies were—despite the monetary losses—more inclined to increase allocation of resources toward social programs like health care. In contrast, authoritarian regimes' social spending policy decisions were more influenced by the debilitating economic forces present (Brown and Hunter 1999, 789). Furthermore, a more comprehensive and recent study of 18 Latin American countries between the years 1970 to 2000 indicated a democracy's greater long-term social expenditure in areas of social security, health, and education in contrast to smaller health and education investment in highly repressive authoritarian regimes (Huber et al. 2008, 420). This spending discrepancy between regime types is accounted for by a democracy's greater public constraints and willingness to provide social goods, especially during times of contentious electoral races (Brown and Hunter 1999, 787), in addition to greater opportunities for "self-organization of the underprivileged and their capacity to push for better health and education services" (Huber et al. 2008, 432). This increase in health care spending within democratic governments is indicative of a better quality of health care for its citizens.

Furthermore, within democracies, barriers to entry and exit are low for leaders, in addition to low costs of participation for citizens (Lake and Baum 2001, 590). Thus, democracies can provide their citizens more avenues for direct and indirect participation in the political process, making it easier to enact the majority's policy goals—particularly better health care

provision. Furthermore, the leaders within democratic regimes are constrained by public opinion, and must enact favorable policy if they wish to remain in office; the costs of establishing a new leader are relatively low within democracies, ordinarily consisting of a free, statewide vote (Lake and Baum 2001, 596). Autocracies, on the other hand, possess high costs of political participation, particularly for dissenters, in addition to high barriers to entry for challengers of the incumbent. Thus, autocratic leaders are less likely to waste monetary resources on improving social goods such as health care when it is likely they will remain in office (Lake and Baum 2001, 596). The assertion that democracies provide a higher level of public health care services than autocracies was confirmed by a global cross-sectional and time varying statistical analysis of various health indicators such as life expectancy and safe water access (Lake and Baum 2001, 617). It is important to note that these citizens are lobbying for their *own* health care interests, and thus removing potential resources for non-citizens.

Hypothesis: Democratic regimes will provide better quality health care for their citizens than authoritarian regimes.

Data & Methods:

In order to accurately answer the premise of the hypothesis, various health indicators were chosen from a dataset obtained primarily from the WorldBank, in addition to the United Nations (UN) and the Uppsala Conflict Data Program (UCDP). The dependent variables chosen measured various aspects of health care including fertility rate (births per woman), improved water source access (% of population), life expectancy at birth (years), human development index (HDI), government expenditure on health (% GDP), and mortality rate under-5 (per 1000). These dependent variables were regressed on the independent variables of regime type as well as

control variables comprised of real GDP per capita and number of conflicts. Regime type was coded as follows: (1) for authoritarian and (0) for democratic (Gandhi 2008). Furthermore, the variables were regressed using a fixed effects model to account for similarities across time between the same countries. The sample consisted of 44 countries within Asia, between the years of 1980 and 2000. An Asian sample was chosen to ensure that the host countries harboring Palestinian refugees experienced the same democratic citizen lobbying and electoral constraints in regards to health care provision, while providing the necessary degrees of freedom.

Results:

Table 1: Regime Type Coefficients

Variables	Fertility Rate	Life Expectancy	HDI	Mortality Rate	Improved Water Source	Govt. Health Expenditure
Regime	0.937*** (.168)	-4.162*** (.621)	-0.048*** (.016)	38.035*** (7.810)	-3.872* (2.156)	0.013 (.182)
Legislature	-0.202* (.103)	1.302*** (.370)	0.018 (.012)	-7.331 (4.551)	(omitted)	0.117 (.113)
Party	-0.255** (.111)	0.602 (.403)	0.009 (.011)	-2.595 (4.989)	-0.004 (2.156)	-0.045 (.133)
Conflict	0.269*** (.061)	-0.192 (.219)	-0.002 (.006)	2.12 (2.592)	-0.458 (.924)	-0.024 (.051)
GDP per Capita	0.000 (.000)	0.000** (.000)	0.000* (.000)	0.000 (.001)	0.000 (.000)	0.000** (.000)
Constant	3.459*** (.304)	65.751*** (1.097)	0.647*** (.030)	50.905*** (13.477)	85.738*** (3.968)	1.043*** (.376)
Observations	391	380	126	190	96	336
F Stat; Prob > F	15.98; .000	21.11; .000	5.45; .000	8.23; .000	0.89; .4749	1.69; .136

***p<0.01 **p<0.05 *p<0.1, standard errors in parentheses

Data Analysis:

The results of the statistical analysis largely confirm existing theory emphasizing a democracy's greater provision of health care services to its citizens in relation to an authoritarian state. The lobbying opportunities and low costs of political participation present within democracies serve to effectively further the collective health care interests of citizens. As depicted by Table 1, regime type significantly affects several health indicators including fertility rate, life expectancy, HDI, mortality rate, and improved water source access. The data trends all followed the pattern of democracy providing higher quality health care. Sample countries identified as authoritarian corresponded with an increase in fertility rate versus democratic states, which is indicative of poorer citizen health. Further, when regime type decreased, indicating democracy = (0), life expectancy increased. The same negative relationship was found for the Human Development Index, which measures health based on life expectancy, education, and per-capita GNI. Democratic countries possessed a higher HDI than autocratic countries. The positive health effects afforded to the citizens of democratic nations was further confirmed by the statistical analyses of mortality rate as well as percent access to improved water sources. Mortality rate is significantly higher in authoritarian regimes within Asia when compared to democracies and the increase in the percent of the population with access to safe water can be significantly explained by democracy as well.

The only health indicator that was not significantly affected by either regime type was percent GDP expenditure on health. This could be an artifact of the many authoritarian Middle Eastern countries that provide generous social benefits, such as universal health care provision, in exchange for a lack of political rights. Nevertheless, these statistical results clearly emphasize that current literature consensus regarding regime type versus health care provision does not

constitute a "fluke" but signals something fundamental about the nature of democracy in providing better health care for its citizens. Democracy actually does seem to be a deciding factor in accounting for the variation in health policies across countries globally. And citizens of democratic countries *do* effectively lobby for their own health care interests, even potentially to the detriment of refugees residing within those democratic countries.

Part II: Does the Degree of Authoritarianism Matter?

Theory:

Are labels such as "democracy" and "autocracy" too restrictive? For instance, North Korea is widely regarded as a much stricter, almost tyrannical, authoritarian regime in comparison to an authoritarian country like Jordan. Is something significant lost to current political science literature when all-encompassing binomial terms such as "democracy" or "autocracy" are used in place of a more varied approach while considering regime type and its effects on health care provision?

Mere "authoritarianism," then, is not an accurate portrayal of the varied regimes that exist in the international political landscape. Regimes can be afflicted with varying degrees of corruption, permit varying levels of public dissension and petition, and protect the right to association, to private property, and to freedom of speech to varying extents. Furthermore, it is assumed that all political leaders seek to remain in office and maximize their personal rents--money, influence, power, prestige or whatever other value the leader gains from maintaining their leadership position. Thus, autocratic leaders may establish democratic institutions, even if only nominally so, as instruments to co-opt public support when compliance is necessary for internal prosperity, and thus maintain a steady flow of high personal rents (Gandhi 2008).

These democratic, or quasi-democratic, institutions allow for gradations in the level of authoritarianism of a country and often appear in the presence of parties or legislatives bodies. Further, these institutions can vary in multiparty (2^{+}) and single party systems as well as appointed, hereditary or elected legislative systems. Similarly, countries can vary in the degree to which they allow for various political rights and civil liberties. Political rights include electoral processes, party systems, and the political treatment of minority groups, while civil liberties include factors such as freedom of speech, assembly, education and belief, personal and financial autonomy, and an impartial judiciary. Clearly variations exist within regime types.

In any case, these democratic institutions serve as ideal forums for citizens to announce policy preferences and provide an institutionalized means of possessing ostensible decision making power in regards to policy outcomes. In addition, institutions are an effective means of safely containing opposition demands for the incumbent autocrat (Gandhi 2008). Thus, citizens of institutionalized authoritarian regimes are provided the important democratic ability to lobby for their health care interests, which contributes to increased constraints on the autocratic leader. As previously stated, such lobbying in democracies leads to an increase in the quality of health care provided to citizens. Current political science literature has failed to obtain significant results in regards to the presence of democratic institutions within authoritarian states and its effects on the provision of social goods (Gandhi 2008). This sets the scene for analyzing the effects of democratic institutions on one specific social good, namely health care, and subsequently whether less authoritarian countries consistently provide better health care to their citizens.

Citizens residing in authoritarian regimes with democratic institutions still lobby effectively to constrain an autocratic leader and constrict his personal freedom to allocate health

care resources toward marginal groups such as refugees. Even if no actual decision-making power is provided to the citizens, the existence of democratic institutions within authoritarian regimes remains a valuable measure of the level of division within the state and the extent of the autocrat's control over his citizens. Citizens residing in democratically institutionalized authoritarian regimes possess leaders who require the cooperation of their citizens and are willing to provide democratic institutions to co-opt public support. Consequently, this leader will possess a disposition more amenable to providing greater social concessions in the form of higher quality health care for his citizens. Theoretically then, health care quality under these autocratic regimes will be better than under those without democratic institutions, ruled by leaders who possess no need to provide health care concessions to their citizens. Thus, not only does regime type account for the differences in health care provision across countries, but the differing levels of authoritarianism across countries accounts for such health variation as well.

Hypothesis: A country's degree of authoritarianism is negatively correlated to the quality of health care provided to its citizens.

Data & Methods:

The statistical analysis of this regression was similar to the method of Part I; however, the health indicators of only the authoritarian regime-coded Asian countries were utilized. This lowered the number of observations to 660 authoritarian samples across a timeline spanning the years 1980 to 2000. Ultimately, the same dataset was used for this regression as in Part I, but with the democratic regime observations omitted. The dependent health indicator variables were then regressed on the party and legislature system (IV) as well as several control variables. First, degree of authoritarianism was measured by focusing on the presence of democratic institutions:

types of parties (more than one = 2; one = 1; non-existent = 0) as well as types of legislatures (elected = 2; appointed = 1; non-existent = 0) (Gandhi 2008). Real GDP per capita and number of conflicts constituted the control variables for the sample and health indicators were identical to the dependent variables used in the Part I regime type study.

Second, to gain a more comprehensive picture of the varying degrees of authoritarianism across countries, Freedomhouse rankings for all of the 44 Asian countries were obtained from a time period spanning the years 2000-2009 as well. These whole integer rankings range from a "free" status ranking of 1 to a "not free" status ranking of 7. In addition, political rights are distinguished from the civil liberties afforded to the citizens of each country. Political rights measure a country's electoral processes, party structure, political pluralism and participation, corruption, as well as the functioning of the government while the civil liberties variable measures freedom of expression and belief, associational and organizational rights, rule of law, personal autonomy, and private property protections (freedomhouse.org). Furthermore, because of the high correlation between the political rights and civil liberties variables, these independent variables were regressed on the subsequent dependent variables separately. Control variables include total population, land area (km^2), and GDP per capita (constant 2000 US$). Number of conflicts was omitted as a control variable due to a lack of data points, which significantly lowered the number of observations in the regressions. The conflict variable was never significant for any of the civil liberties or political rights regressions; however, removing this control did allow significant results for the civil liberties variable in relation to different health indicators. Finally, health indicators obtained from the WorldBank database include the human development indicator (HDI), physicians (per 1,000 people), infant mortality rate (per 1,000 live births), under-5 mortality rate (per 1,000), life expectancy at birth (years), improved water source

(% of population with access), hospital beds (per 1,000 people), public health expenditure (% of GDP), health expenditure per capita, PPP (constant 2005 international $), and fertility rate (births per woman).

Lastly, by analyzing the effect of degrees of authoritarianism on an Asian country sample, citizen health care lobbying and leader constraint effects can be plausibly extended toward the Middle Eastern Palestinian refugee host country experiences. Furthermore, this allows for the effects of these democratic institutions to be measured with an appropriate number of degrees of freedom. Because all the Palestinian host countries are considered authoritarian states, the question of whether a country's level of authoritarianism significantly affects the health care quality provided to citizens possesses important implications for the refugees of those host countries.

Results:

Table 2: Legislature and Party (authoritarian countries only)

Variables	Fertility Rate	Life Expectancy	HDI	Mortality Rate	Improved Water Source	Govt. Health Expenditure
Legislature	-0.277**	1.632***	0.017	-10.556*	(omitted)	0.154
	(.115)	(.427)	(.014)	(5.382)		(.110)
Party	-0.258**	0.721	0.021*	-5.966	-0.001	-0.001
	(.130)	(.488)	(.013)	(6.469)	(2.196)	(.158)
Conflict	0.674***	-1.302***	-0.037***	13.383***	-1.964*	0.024
	(.094)	(.364)	(.010)	(4.271)	(1.153)	(.072)
GDP per Capita	0.000*	0.000	0.000	0.000	0.000	0.000
	(.000)	(.000)	(.000)	(.001)	(.000)	(.000)
Constant	4.394***	62.311***	0.615***	88.026***	82.717***	1.368***
	(.244)	(.898)	(.026)	(11.297)	(3.240)	(.280)
Observations	297	275	90	136	65	228
F stat; Prob > F	15.27; .000	6.89; .000	4.08; .006	3.08; .0198	0.97; .4175	0.72; .577

***p<0.01 **p<0.05 *p<0.1, standard errors in parentheses

Table 3: Civil liberties coefficients

Variables	Fertility Rate	Life Expectancy	HDI	Govt. Health (%GDP)	Govt. Health Per Capita
GDP per Capita	0.000**	0.000***	0.000*	0.000	0.020*
	(.000)	(.000)	(.000)	(.000)	(.007)
Land Area	0.000**	-0.001***	0.000	0.000	-0.001
	(.000)	(.000)	(.000)	(.000)	(.040)
Population Size	0.000***	0.000***	0.000**	0.000	0.000
	(.000)	(.000)	(.000)	(.000)	(.000)
Civil Liberties	0.092***	-0.241**	-0.009**	-0.007	-21.798
	(.026)	(.107)	(.004)	(.083)	(14.342)
Constant	-97.85**	604.754***	2.807	-136.794	1279.329
	(44.867)	(176.608)	(4.153)	(178.56)	(31400.77)
Observations	361	362	101	200	193
F stat; Prob > F	27.09; .000	38.55; .000	4.90; .002	1.17; .328	17.28; .000

Variables	Hospital Beds	Physicians	Improved Water Source	Mortality Rate (<5)	Infant Mortality Rate
GDP per Capita	0.000**	0.000**	0.000	0.000	0.000
	(.000)	(.000)	(.000)	(.000)	(.000)
Land Area	0.000	0.000	-0.002	0.003	0.002
	(.000)	(.000)	(.001)	(.003)	(.002)
Population Size	0.000	0.000	0.000***	0.000***	0.000***
	(.000)	(.000)	(.000)	(.000)	(.000)
Civil Liberties	0.174	0.024	-1.972***	4.968***	3.476***
	(.113)	(.069)	(.621)	(1.273)	(.884)
Constant	246.274	36.734	1566.597*	-2354.514	-1296.563
	(193.829)	(154.304)	(908.255)	(1954.74)	(1381.168)
Observations	172	126	109	201	207
F stat; Prob > F	1.20; .313	1.56; .193	7.20; .000	14.30; .000	14.64; .000

***P<0.01 **P<0.05 *P<0.1, standard errors in parentheses

Table 4: political rights coefficients

Variables	Fertility Rate	Life Expectancy	HDI	Govt. Health (%GDP)	Govt. Health Per Capita
GDP per Capita	0.000***	0.000***	0.000*	0.000	0.024**
	(.000)	(.000)	(.000)	(.000)	(.007)
Land Area	0.000**	-0.001***	0.000	0.000	-0.001
	(.000)	(.000)	(.000)	(.000)	(.040)
Population Size	0.000***	0.000***	0.000**	0.000	0.000
	(.000)	(.000)	(.000)	(.000)	(.000)
Political rights	-0.030	0.150	0.005	0.137	-22.336
	(.021)	(.086)	(.003)	(.061)	(10.45)
Constant	-105.206**	630.475***	2.440	-138.357	1323.391
	(44.636)	(180.767)	(4.302)	(178.814)	(31418.6)
Observations	361	362	101	200	193
F stat; Prob > F	19.45; .000	33.9; .000	3.62; .011	1.05; .384	17.22; .000

Variables	Hospital Beds	Physicians	Improved Water Source	Mortality Rate (<5)	Infant Mortality Rate
GDP per Capita	0.000	0.000**	0.000	0.000	0.000
	(.000)	(.000)	(.000)	(.000)	(.000)
Land Area	0.000**	0.000	-0.003**	0.005*	0.003
	(.000)	(.000)	(.001)	(.003)	(.002)
Population Size	0.000	0.000	0.000***	0.000***	0.000***
	(.000)	(.000)	(.000)	(.000)	(.000)
Political rights	0.289	0.039	0.259	0.043	0.130
	(.134)	(.096)	(.548)	(.929)	(.646)
Constant	395.088**	40.125	2144.373**	-3430.388*	-2003.946
	(191.345)	(154.306)	(1006.041)	(2065.719)	(1459.021)
Observations	172	126	109	201	207
F stat; Prob > F	2.29; .063	1.57; .190	4.12; ,005	9.56; .000	9.84; .000

***P<0.01 **P<0.05 *P<0.1, standard errors in parentheses

Data Analysis:

In regards to democratic institutions (Table 2), the hypothesis that possessing these institutions would increase national health was largely upheld. As the presence of legislative and party institutions decreases in authoritarian states, or as states become more authoritarian and do not provide democratic institutions, fertility rate increases significantly—a sign that designates a decrease in national health. When the legislative institution increased in democratic nature, life expectancy increased in addition to a significant decrease in under-5 child mortality rates--national health increased. The greater policy making and lobbying power that is associated with the legislative branch of the government allows citizens to possess a more direct influence on leaders within the legislature and to overtly press for greater health benefits for citizens at the expense of refugees. Additionally, when authoritarian states provided more democratically oriented party institutions, it corresponded with a subsequent increase in the human development index. Furthermore, the coefficients of the significant results in Table 2 for legislature and party are larger than the corresponding coefficients in Table 1, where democratic regimes were included in the regressions. This presumably indicates the greater influence that these democratic institutions possess within authoritarian regimes, where citizens are typically denied such methods of political participation, on spurring greater health care gains for citizens. Thus, the data show that the mere presence of democratic institutions acts as a boon to an autocracy's citizens in regards to health care provision.

When measuring degrees of authoritarianism using Freedomhouse rankings, the same trend touting the positive effects of decreased levels of authoritarianism on health care quality is maintained. Civil liberties and political rights are both different measures of the "freedom" of a country, whose effects are difficult to separate from each other. Nevertheless, democracies are

typically associated with the presence of various political rights and civil freedoms largely absent in autocracies, whose leaders do not need to serve the interests of the entire citizen population. The level of civil liberties present in a country produced results congruent with the hypothesis--as citizens were provided more "democratic" freedoms, there was a subsequent rise in quality of national health. Specifically, as shown by Table 3, an increase in civil liberties (which corresponds to a *decrease* in the numerical scale), in other words a more democratic state, results in a corresponding significant decrease in fertility rates, increase in life expectancy, increase in HDI, increase in access to improved water sources, and a decrease in the infant mortality rate as well as the under-5 mortality rate. When citizens can freely assemble and disseminate information openly, important health information can spread more rapidly and proper health practices can be discussed widely in public forums. Furthermore, when private enterprise and property is protected by the state, quality health care is more easily accessed and affordable. And when citizens lobby for their health care interests in democratic institutions, leaders are constrained to appeal to the larger constituency by providing broad public goods such as health care. Ultimately, the evidence strongly indicates that authoritarian--and even democratic--regimes are not static, homogenous entities, and that the variation between different authoritarian states does possess a significant impact on a country's quality of health care provision toward its citizens.

Furthermore, the consistent non-effect of regime type, civil liberties or political rights, and democratic institutions on the government health expenditure of a country possesses interesting implications for the role of the state in promoting the health of its citizens. States that possess democratic institutions, or that are less authoritarian according to Freedomhouse rankings, promote public health not necessarily by increasing government spending on health

programs, but by promoting an environment conducive to the presence of civil liberties and political rights typical of democracies. Maintaining an infrastructure that promotes a citizen's ability to lobby for her own particular health interests or to freely discuss various public health measures—creating a foundation built on democratic freedoms—significantly affects a nation's public health and may encourage private health care establishment. Furthermore, the presence of democratic institutions may not necessarily increase government health care spending, but simply make spending more efficient, accountable, and focused on targeting a greater distribution of citizens. Leaders of authoritarian states with democratic institutions are more constrained by their larger constituency to distribute health care spending more equitably.

Part III: What About the Refugees?

Theory:

Current political literature regarding regime type and its effects on health care provision largely focuses its attention on the implications for *citizens* of the state. But what about the stateless? Do refugees possess enough influence to significantly change a political leader's actions in regard to state health care provision? Is the theoretical mechanism for refugees similar to that of citizens or does the current citizen-focused theory need to be amended to account for refugees' influence within their respective host countries? If so, it would signal an important addition to the political literature regarding individuals often forgotten and assumed to be without a political voice.

Refugees, by their very nature, are often overlooked—in legal protections, in politics, in polite conversation. However, it seems a bit brazen to neglect the impact refugees may have on the policies of a host country—for example, Palestinian refugees comprise 33.4 % of the total

Jordanian population, at 1.9 million registered refugees (Annual Report, 2007). This is further compounded by the unfortunate longevity—over 50 years—of a Palestinian refugee presence in the Middle Eastern region. Since the aftermath of the 1948 Arab-Israeli Conflict, Palestinians have been residing in dilapidated, "temporary" camps, confronted with frequent disruption of access to basic services such as education, housing, and health care due to checkpoints erected by the Israeli military—over 600 established by June 2008—to block Palestinian movement (Giacaman et al. 2009, 840). Furthermore, they must cope with curfew, housing demolitions, land confiscations, severe infrastructure damage in addition to restriction from accessing key water resources, as well as the psychological distress and uprooted social order associated with such a lifestyle (Giacaman et al. 2009, 839). Emergency medical vehicles are routinely stopped and delayed at various checkpoints instituted by the Israeli government around the West Bank and Gaza. The United Nations Relief and Works Agency (UNRWA) has, since 1949, specifically focused on assisting the 4.7 million registered Palestinian refugees located across a Middle Eastern region encompassing the West Bank, Gaza, Jordan, Lebanon, and Syria. In the face of such apparent powerlessness, it would be easy to assume negligible impact on state policy. Yet sixty years residing in the same area must build up some political influence and produce a measurable impact on local policy.

It has already been established that less authoritarian states provide better health care to their citizens due to the democratic effects of citizen lobbying and leaders catering to larger constituencies. But does this tenet still hold true for non-citizens, like Palestinian refugees, who primarily reside in four different autocratic Middle Eastern host countries, each with a different degree of authoritarianism? As non-citizens of the state, refugees cannot feasibly interact with provided democratic institutions like parties or legislatures. However, refugees can still partially

reap the benefits of broad public goods such as civil liberties--freedom of association and expression, protection of economic activity, and fair rule of law. While technically not afforded these rights because they are not citizens, refugees can benefit from an atmosphere of ample civil liberties conducive to promoting public health. For instance, discouraging Palestinian refugees from freely associating would be much more difficult to enforce if the government already provided such rights to citizens. Like the citizens of the state, broadly accessible public goods such as civil liberties will likely encourage positive interaction with the state and lead to an increase in national health.

Additionally, refugees can and do influence members of the "selectorate" who *do* possess the political rights to interact with provided democratic institutions. Selectorate theory posits that each regime leader maintains office through the selectorate, or the special segment of the population that possesses decision-making power in regards to establishing a political leader (Bueno de Mesquita et al. 2003). For example, the selectorate in a democracy would be all those citizens eligible to vote. In contrast, the selectorate in an authoritarian state can be much smaller and is typically comprised of influential members of the state such as military leaders and wealthy businessmen (Bueno de Mesquita et al. 2003). Each leader must surpass the threshold set by the winning coalition, or the proportion of selectorate support necessary for the leader to maintain power (Morrow et al. 2008, 393). Subsequently, leaders maintain office by distributing public goods and private benefits toward the support coalition, or the segment of the selectorate that prevailed in establishing their leader of choice (Morrow et al. 2008, 393).

If the support coalition segment of the selectorate falls below the winning coalition threshold, then the leader is vulnerable to removal from office by a challenger (Morrow et al. 2008, 393). In democracies, maintaining office entails enacting the policy preferences of the

support coalition while offering some political concessions to the entire selectorate. Because of the larger size of the selectorate and winning coalition, these concessions are usually in the form of broad public goods, such as health care, national security, and effective economic policies, that can be distributed to and benefit efficiently the most members of the selectorate. In authoritarian states, these rewards manifest themselves in the form of private benefits to the select few members of the support coalition that comprise the typically smaller winning coalition. This smaller selectorate size encourages the distribution of private goods such as tax breaks, manufacturing monopolies, and direct financial payments to maintain support above the winning coalition minimum (Morrow et al. 2008, 393). Selectorate theory remains a reputable theory that retained its legitimacy against criticisms concerning residualization methods and has continued to be a significant predictor of public and private goods provision in terms of winning coalition size (Morrow et al. 2008, 399).

How do democratic institutions and non-selectorate members, such as refugees, play a role in selectorate theory? In democracies the leader possesses a large selectorate and winning coalition size, and thus it is more efficient to distribute broad public goods, such as health care, to cater to his constituency. Non-selectorate members, as in refugees, can largely partake in these broad public goods, unless it is required to be a citizen in order to receive the benefits (Figure 1). Authoritarian leaders, on the other hand, will likely distribute a small amount of earned rents toward non-selectorate members in show of self-preservation. In authoritarian states, non-selectorate members comprise a majority of the population--their cooperation is essential for internal prosperity, and discord within the non-selectorate population can lead to potential problems for individuals who *are* members of the selectorate. Thus, in regards to health care provision, authoritarian leaders will provide some measure of health care to non-selectorate

citizens and refugees residing within the country to prevent a health epidemic or mass protests--whose negative effects could trickle down to members of the selectorate and result in the leader's removal from office (Figure 1).

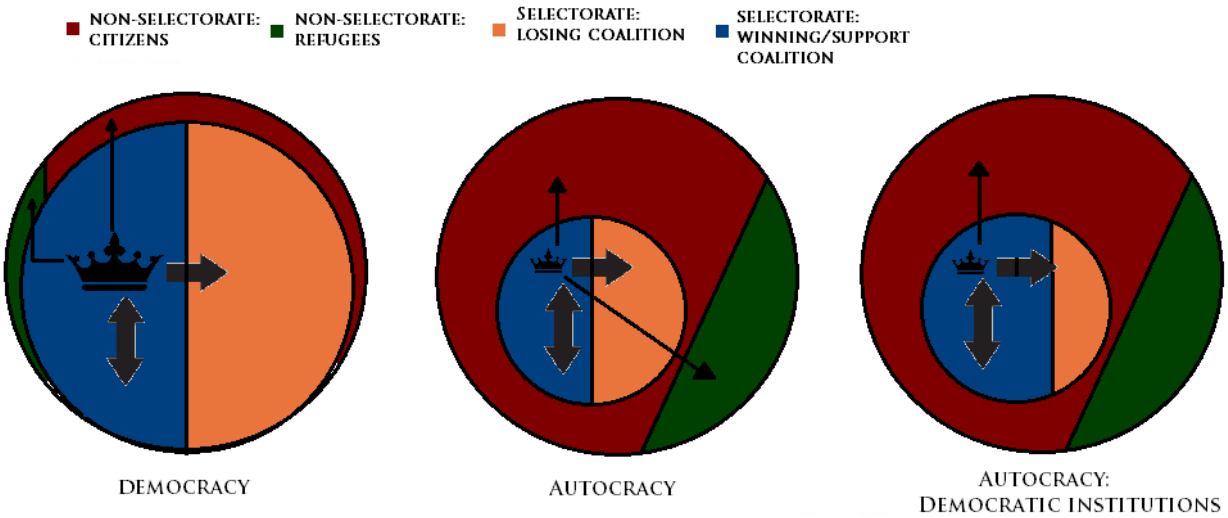

Figure 1. Selectorate Theory

When authoritarian leaders provide democratic institutions, even "sham" democratic institutions, they inevitably increase the size of their winning coalition and decrease the influential power of each individual member of the selectorate. This results in decreased personal rents for the autocrat because more of his personal stores must be distributed to the larger winning coalition, more likely in the form of more efficient broad public goods. It has already been shown that the provision of institutions such as a legislature and party system increase national health within authoritarian regimes. Thus, when citizens lobby within these democratic institutions for increased state health care spending for fellow citizen members of the selectorate and winning coalition, the autocratic leaders become constrained by the public opinion. Subsequently, spending that would have been distributed towards non-selectorate members, namely refugees, are now given to the citizens instead (Figure 1). Thus, these leaders are more inclined to turn to third party organizations such as the United Nations Relief and Works Agency

*(*UNRWA) to provide for refugee healthcare--and in the process keep a greater amount of personal rents for themselves. On the other hand, authoritarian leaders who do not possess such institutions would be more reluctant to increase their selectorate size and partially forfeit authority over to organizations such as the UNRWA, despite the prospect of free refugee healthcare. Nevertheless, if the citizens of a country possess strong ties to the refugee population and lobby for refugee health care interests within existing democratic institutions in addition to their own, then authoritarian leaders will be more likely to personally distribute as well as to rely on third-party organizations to provide public goods such as health care.

Hypotheses:

1. Those refugees residing in host countries with a greater number of democratic institutions will receive a poorer quality of health care from the state, and subsequently have a greater reliance on health care provision by third party organizations.
2. Refugee health care will significantly increase in quality when there are strong ties between the host country citizens and the refugees, in addition to democratic institutions.

Data & Methods:

Palestinian refugee health indicators were obtained primarily through datasets provided by the UNRWA. Data was provided for the four main Palestinian refugee host countries: Jordan, Lebanon, Syria, and the West Bank & Gaza. Health indicators include total fertility rate, aging index, primary healthcare facilities per 100,000, doctors per 100,000 registered refugees, nurses per 100,000 registered refugees, annual per capita health budget allocations (US$), infant mortality (per 1000 live births), child mortality rate (< 3 years) per 1000 live births, prevalence of anemia among children < 3 years of age, percentage of camp shelters with access to sewerage

facilities, prevalence of hypertension among population served 40 years and above (%), and number of mumps cases reported. These Annual Health Reports are available for the years 2009, 2007, 2006, 2004, and 2003. Freedomhouse civil liberties rankings for the four host countries were used to measure democracy generally. Finally, graphs were prepared charting the progression of a single host country's civil liberties score as well as one health indicator across the years 2000-2009.

Additionally, the UN mandated allocation of health resources, detailed by the UNRWA Health Reports, was compared to healthcare data for the general population of each host country. Host country health statistics were compared with correlating Palestinian refugee health care statistics to derive a ratio of citizen versus refugee health care quality indicators. The reasoning following that those countries approaching a 1:1 ratio of citizen versus refugee health care indicators would be providing the greatest allocation of state resources toward refugee health care provision. Subsequently, those with large discrepancies in refugee versus citizen health care ratios would be largely relying on the UNRWA for refugee health care and not allocating a large amount of state resources toward refugee health care concerns. Ratios were derived by dividing host country statistics by Palestinian refugee statistics for the health indicators comprised of: percent sewage facility access, health expenditure per capita, mortality rate under-5 (per 1,000), mortality rate infant (per 1,000 live births), and physicians (per 100,000 people).

Data Analysis:

Based upon general Freedomhouse rankings during the 21st century, the four Palestinian refugee host countries, ranked from least to most authoritarian, are Jordan, Lebanon, West Bank & Gaza, and Syria. It is also important to note the unique case of the West Bank & Gaza as

territories occupied by Israel, as well as to account for the Gaza War that occurred between the years 2008-2009. When comparing the ratios of health indicators between state and UNRWA figures, the data are remarkably similar to expected values. Syria consistently recorded values close to a 1:1 ratio, indicating the greatest state involvement in health care provision for Palestinian refugees. For instance, for the Health Spending per Capita ratio, Syria averaged around 10, Lebanon 25, and Jordan 50 (data missing for West Bank & Gaza). Regarding the physicians per 100,000 ratio, Syria remains closest to 1:1 with a ratio of 4, followed by the West Bank & Gaza at 9, Lebanon 23, and Jordan 48. Palestinian refugees harbored within Syria, while not considered citizens, are entitled to full social rights (Sabatinelli 2009, 1063), consistent with the theory of autocratic, democratic institution-absent, leaders possessing much more freedom to distribute small social goods such as healthcare to non-selectorate members.

For both child and infant mortality, however, Syria recorded a ratio of .5, Lebanon .7, Jordan around 1, and the West Bank & Gaza at 1.25. This time Jordan possessed the ratio closest to 1:1. Similarly for the sewage facility access ratio, Jordan and Syria both possessed a value around 1, with the West Bank and Gaza around 1.23 and Lebanon around 1.35. This could be due to the large proportion—almost a third of the population—of Palestinian refugees living in Jordan. Palestinians residing in Jordan are uniquely entitled to Jordanian citizenship unless they have emigrated from the Gaza Strip. If so, they face several restrictions concerning higher education access as well as prohibition from certain civil services (Sabatinelli 2009, 1063). Such discrimination occurs due to the Jordanian government seeking to dispel images of the country as a dumping ground for Palestinians unwanted by the Israeli government. Nevertheless, this ubiquitous Palestinian presence likely forged strong ties between refugee and Jordanian citizens

and resulted in selectorate lobbying within democratic institutions for increased health care provision for the refugees.

Overall, Lebanon, the second-least authoritarian country, seems to have provided the poorest quality health care to the Palestinian refugees, requiring the UNRWA to provide medical treatment to its refugee population. The lack of significant ties between members of the selectorate and the refugees, along with the constraints likely placed on Lebanon's leader regarding increased citizen-focused health care spending remains a plausible explanation for this phenomenon. Palestinian refugees in Lebanon are "exonerated from the national taxation system but excluded from social security, and prevented from practicing 70 different professions including medicine…making this refugee community the most vulnerable and financially dependent of those served by the UNRWA outside the occupied Palestinian territory" (Sabatinelli 2009, 1063). And concerning the West Bank and Gaza, Palestinian refugee autonomy is severely limited by the Israeli military occupation and refugees within this territory are among those with the lowest life quality among all the countries surveyed by the WHO. Respondents expressed high levels of fear, anxiety, and threats to personal and familial safety (Giacaman 2009, 842). Thus, highly authoritarian regime leaders still possess free discretion to choose not to provide specific non-selectorate members access to broad health care goods. Yet even refugees within the Occupied Territories possess standards of health, literacy, and education generally higher than several surrounding Arab countries (Giacaman 2009, 842).

While lacking the firm reliability of statistically significant evidence, the following graphs remain an important tool in outlining general trends regarding host country health care provision to Palestinian refugees. Civil liberties constitute broad social goods that can be shared with non-selectorate refugee members of the population, and potentially increase refugee health.

As a measure of democracy, however, expected results entail an increase in public health provision as civil liberties decrease (numerically increase), or as countries become more authoritarian. In conjunction with each host country's health policies toward refugees in addition to the health indicator ratios, the following graphical trends constitute compelling evidence of the expected results.

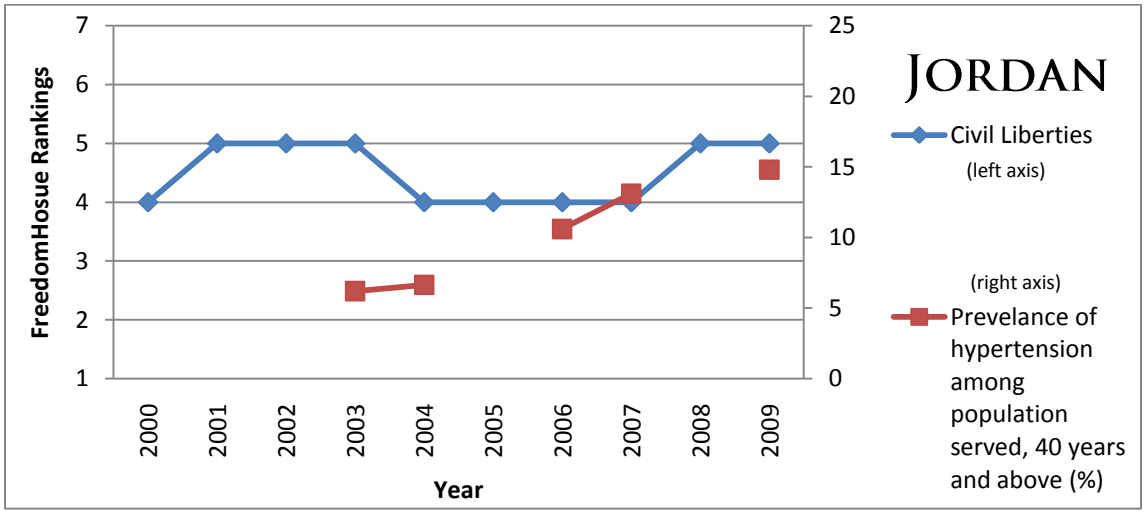

Figure 2 Jordan: Hypertension Rates

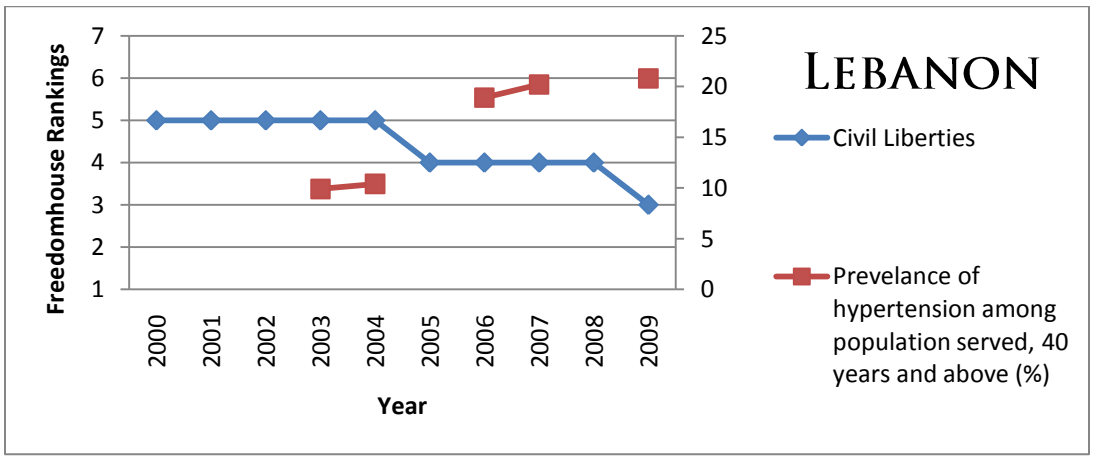

Figure 3 Lebanon: Hypertension Rates

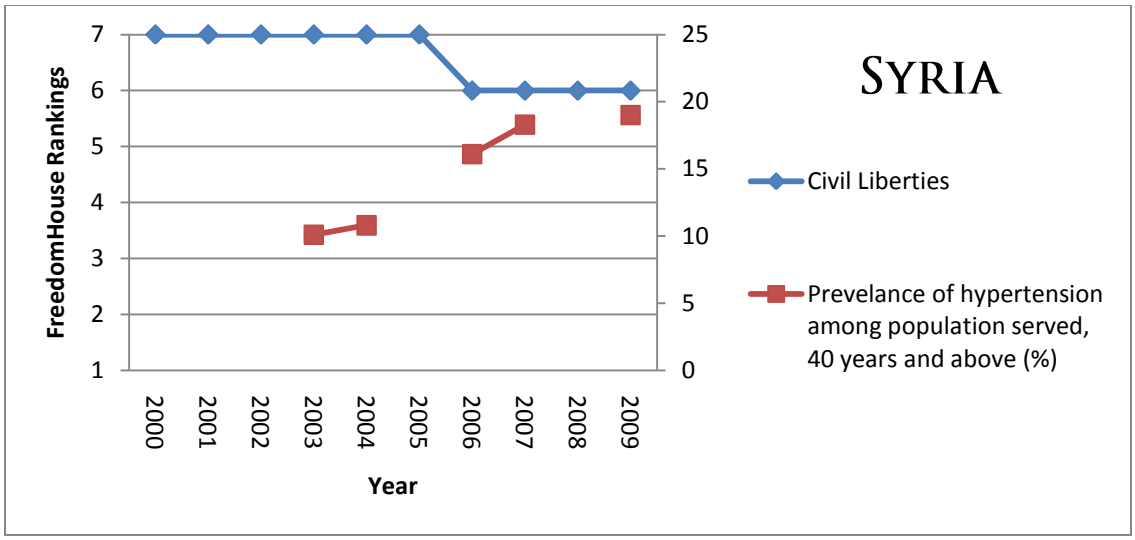

Figure 4 Syria: Hypertension Rates

The percent hypertension prevalence health indicator illustrates the expected trend of more authoritarian states providing a measurably better quality of health care to its refugee population. For instance, in Figure 2, when Jordan experienced an increase in democratic nature (5 to 4) between 2003 and 2004, there was a corresponding increase in hypertension rates within its refugee population. Undoubtedly, there is difficulty in interpreting results when variation in the "democracy" variable occurs at most by increments of one, in addition to the scarcity of data points for the refugee health indicators. However, when taken together with Jordan's close 1:1 ratio of citizen versus refugee health indicators, as well as Jordan's current policy of granting citizenship to Palestinian refugees, expectations seem to be validated by the evidence. Furthermore, Lebanon, a host country with large discrepancies between refugee and citizen health indicator ratios—suggesting a lack of government involvement in refugee health care provision—experienced increased hypertension rates when the "democracy" variable increased. In Figure 3, a higher level of democracy between the years 2004 and 2005 (5 to 4) as well as 2008 and 2009 (4 to 3), correspond with an increase in hypertension rates from 9.9% in 2003 to an eventual increase to 20.8% in 2009. The Lebanese autocratic leader likely cannot cater to

refugee interests when constrained first by citizen interests, as evidenced by Lebanon's denial of refugee access to state health care. The more autocratic host country Syria, however, allows refugees access to the state health care system and possessed health indicator ratios much closer to a 1:1 relationship. And as evidenced by Figure 4, an increase in the regime's democratic nature between the years of 2005 to 2006 (7 to 6) correlated with a jump in refugee hypertension rates from 10.8% in 2004 to 16.1% in 2006 and eventually to 19% in 2009. The Syrian leader most likely became constrained to allocate more state health care resources toward citizens comprising the larger selectorate at the expense of refugee health care concerns. This manifested itself in higher Palestinian refugee hypertension rates.

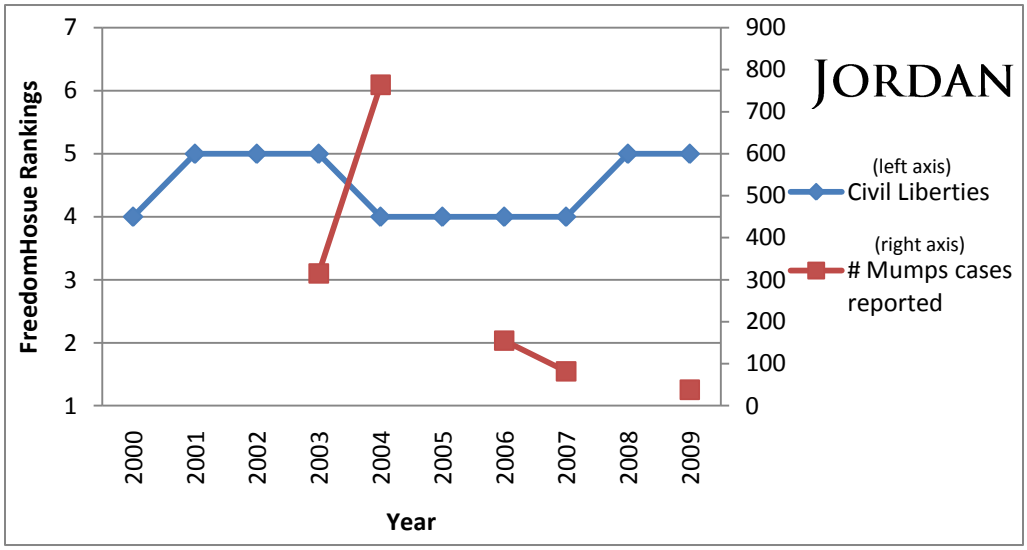

Figure 5 Jordan: # Mumps Cases

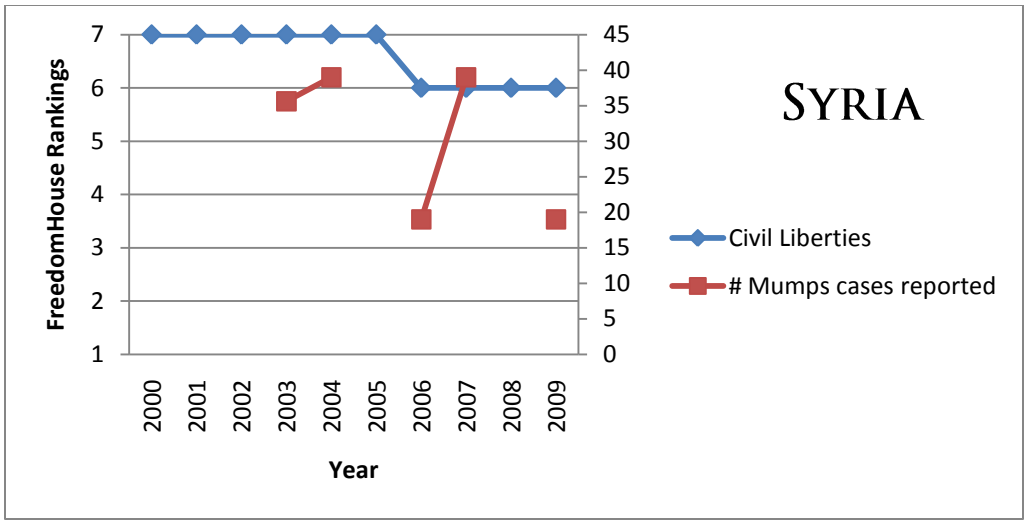

Figure 6 Syria: # Mumps Cases

A similar story can be interpreted from the health indicator, number of mumps cases reported. Both Syria and Jordan undergo similar trends where an increase in the democratic nature of a regime corresponds with an increase in number of mumps cases reported, or a decrease in refugee health. For instance, in Figure 5, Jordan experiences an increase in democracy between the years 2003 and 2004 (5 to 4) and subsequently undergoes a sharp spike in the number of mumps cases reported—from 315 in 2003 to 764 in 2004. Further, the number of mumps cases stabilizes to a count of 38 in 2009 after a corresponding decrease in democracy between the years 2007 and 2008 (4 to 5). Perhaps the Jordanian autocratic leader was constrained against investing in health care resources for refugees under periods with greater democratic institutions, but once taken away, had freer rein to combat a potentially disastrous outbreak that could trickle up to selectorate members. Figure 6 depicts an increase in the number of mumps cases reported (19 to 39) during 2006 to 2007 after a previous increase in democracy (7 to 6) in 2006.

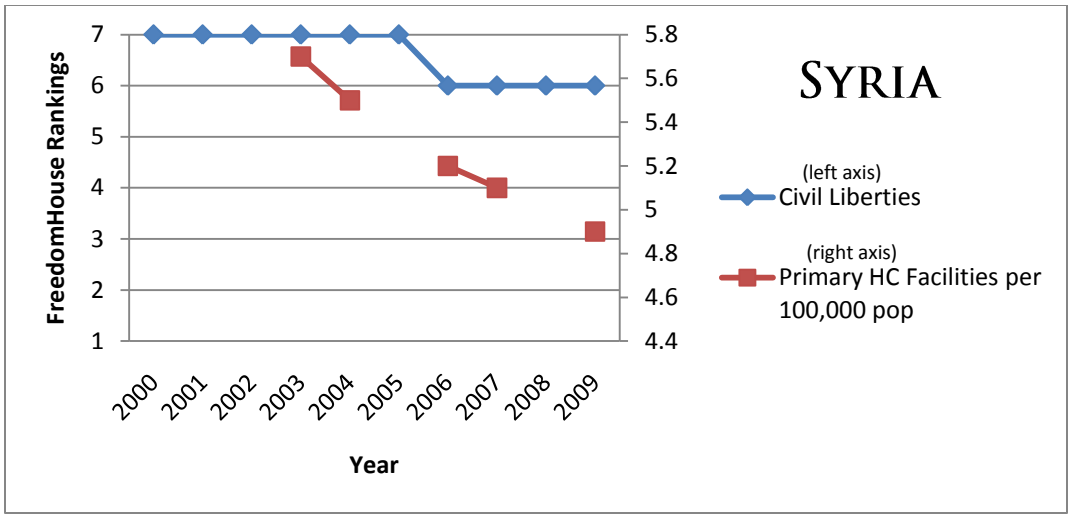

Figure 7 Syria: Primary Health Care Facilities

Finally, after an increase in Syria's democratic ranking between the years 2005 and 2006 (7 to 6), the number of primary healthcare facilities devoted to refugees decreased, from 5.7 in 2003 to 4.9 in 2009. Thus, the trends indicate an overall decrease in refugee health care provision when authoritarian states increase in democratic nature or acquire more democratic institutions.

Conclusion:

There are undoubtedly numerous reasons for the lack of accounting for refugee populations in the current political literature--lack of data, the transient nature of refugees, the greater policy impact of citizens. However, by including the effects of refugees within the context of current theories concerning regime type and its effects on health care quality, a clearer image of a complex political mosaic can be obtained. Democracy, however, appears to be doing its job: serving the interests of its constituents, and providing political freedoms and broad social goods to its citizens—even at the expense of non-citizen refugees. This can hardly be considered a "bad" thing. However, refugees remain human beings that matter not only in a human context, but in a political context as well.

Thus, what are the implications of these findings? Are refugee and citizen interests inherently in opposition to one another? Not necessarily. Further research should be conducted to assess if these results can be extended to other refugee populations, as well as how refugees can forge solid ties with host country populations and lobby for shared health care interests. Further, this research does not advocate that refugees fleeing from oppression should seek out harshly authoritarian regimes in favor of democratic countries like the United States. Such refugees must consider the full impact a host country will have on numerous aspects of their lives—a fair legal system, a culture of political and civil freedoms, ample economic and welfare opportunities—not just health care provision. Rather, when faced with a choice between an authoritarian regime with or without democratic institutions, refugees will likely encounter a greater degree of health care provision when the autocratic host country leader is not constrained by citizen interests in the form of democratic institutions. Perhaps the rapid, democratically-oriented revolutionary movements currently spreading across the Middle East will correspond to new developments in the health care provision for long-term citizens as well as refugees. Nevertheless, rather than viewing previous research as a diatribe against autocracy or democracy, hopefully the intricate relationship between refugees, citizens, health care, and the governments they live under has become slightly more illuminated.

Works Cited

"Annual Report of the Department of Health 2003." *unrwa.org*. UNRWA. (2003) 20 Sept, 2010.

"Annual Report of the Department of Health 2004." *unrwa.org*. UNRWA. (2004) 20 Sept, 2010.

"Annual Report of the Department of Health 2006." *unrwa.org*. UNRWA. (2006) 20 Sept, 2010.

"Annual Report of the Department of Health 2007." *unrwa.org*. UNRWA. (2007) 20 Sept, 2010.

"Freedom in the World." *Freedomhouse.org*. Freedomhouse, Inc, 2010. 30 September 2010.

"Refugee Figures." *UNHCR.org.* UNHCR: The UN Refugee Agency, 2010. 4 November 2010 <http://www.unhcr.org/pages/49c3646c1d.html>.

Brown, David S., and Wendy Hunter. "Democracy and social spending in Latin America, 1980-92." *The American Political Science Review* 93.4 (1999): 779-790. ProQuest. 6 Oct. 2010. <http://proquest.umi.com/pqdweb?did=47605218&sid=1&Fmt=4&clientId=18938&RQT=309&VName=PQD>

Bueno de Mesquita, Bruce, Smith, Siverson, and Morrow. *The Logic of Political Survival.* Cambridge, MA: The MIT Press, 2003.

Gandhi, Jennifer. Political Institutions Under Dictatorship. New York, NY: Cambridge University Press, 2008.

Giacaman, Rita, Rana Khatib, Luay Shabaneh, Asad Ramlawi, Belgacem Sabri, Guido Sabatinelli, Marwan Khawaja, and Tony Laurance. "Health status and health services in the occupied Palestinian territory." *LANCET* Volume 373 Issue 9666 (7 March 2009):

837-849. 7 October 2010. < http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2809%2960107-0/abstract>.

Huber, Evelyne, Thomas Mustillo, and John D. Stephens. "Politics and Social Spending in Latin America." *Journal of Politics* 70.2 (2008): 420-436. 6 Oct. 2010. <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=1818152>

Lake, David A, and Matthew A. Baum. "The Invisible Hand of Democracy: Political Control and the Provision of Public Services." *Comparative Political Studies* 34.6 (2001): 587-621. 4 November 2010.

Morrow, James D., Bruce Bueno de Mesquita, Randolph M. Siverson, Alastair Smith. "Retesting Selectorate Theory: Separating the Effects of *W* from Other Elements of Democracy." *American Political Science Review*. 102.3 (2008): 393-400. 21 March 2011 <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=2300172>.

Sabatinelli, Guido, Stefania Pace-Shanklin, Flavia Riccardo, and Yousef Shahin. "Palestinian refugees outside the occupied Palestinian territory." *The Lancet* Volume 373 Issue 9669 (28 March 2009): 1063-1065. 21 March 2011. <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)60101-X/fulltext#>.

worldbank.org. The World Bank Group, 2010. 6 October 2010.