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This paper relies on administrative, household surveys and qualitative data to answer three questions about the services provided by faith-inspired health care providers in Ghana, asking: (1) what is the market share of faith-inspired providers as compared to other types of providers; (2) are there differences in market shares among the poor between faith-inspired providers and other types of providers; and (3) how satisfied are patients with the services received and why are patients choosing faith-inspired providers for care? While estimates based on facilities data, especially for hospitals, suggest that the market share of faith-inspired providers is at 30 percent to 40 percent, estimates from household surveys are at less than ten percent. The market share among the poor of faith-inspired providers appears to be similar to that of public providers, but higher than that of private non-religious providers. The qualitative data suggests that the reasons that lead patients to choose faith-inspired providers are not related directly to religion per se, but rather (perhaps indirectly) to the quality of the services provided, including (but not only) through the values of dignity and respect for patients that these facilities exhibit.

INTRODUCTION

It is commonly accepted that faith-inspired institutions (FIIs) provide a substantial share of health services in sub-Saharan Africa. To substantiate this perception, one would ideally like to have a comprehensive assessment of the scope and scale of all health-related services provided not only by government facilities and faith-inspired providers , but also by private-for-profit providers and other non-religious not-for-profits (NGOs), community-based organizations and initiatives - including division into engagement in particular response such as HIV/AIDs. Such comprehensive overviews are unfortunately not available at this stage.

It is nevertheless possible to take one (partial) step towards such comprehensive assessments in specific countries by comparing and interpreting the market share estimates for the health care services provided by various types of providers obtained with both facilities and household survey data, and to measure the facilities' 'reach to the poor' (understood here as a comparative market share assessment of various types of providers among segments of the population according to their level of well-being, and

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especially among the poor). In addition, qualitative work can help reveal the reasons why patients tend to choose one type of provider versus another.

The objective of this paper is to do precisely this in the case of Ghana. The main faith-inspired providers[2] in Ghana is the Christian Health Association of Ghana or CHAG, an umbrella organization that coordinates the activities of Christian Health Institutions and Christian Churches' health programs in Ghana. The federation was founded in 1967 as a Voluntary Professional Association with the assistance of the World Council of Churches, the Catholic Bishops Conference and the Christian Council of Zambia. It is a body through which most of the Christian health facilities liaise with the Ministry of Health to ensure proper collaboration and complementation of government efforts at serving the health needs of the population (Schmid et al 2008, Boateng 2006, CHAG 2003, 2006, and 2008, Dieleman and Hilhorst 2009). CHAG is open to any Christian medical institution recognized as such by the Ministry of Health in Ghana. The founding members are the Ghana Catholic Bishops Conference, the Christian Council of Ghana, and the Ghana Pentecostal Council, while the institutional members are the hospitals and clinics that belong to the founding members and share in the responsibilities and benefits of CHAG. Associate members are other Church-related institutions which share in the aims and objectives of the association and in some limited benefits and responsibilities.

The number of CHAG Member Institutions or facilities has grown from 25 in 1967 to 182 in 2011, now including 58 hospitals. The bulk (some 70 percent) of the institutional members are associated with the Catholic Church. A significant event in the relationship between CHAG and the Ministry of Health (MoH) was the government-commissioned Adibo Committee in 1975 which led to public subsidies for the salaries for Ghanaian staff working in mission hospitals. Another watershed moment came in 2003 at the signing of a Memorandum of Understanding (MOU) between CHAG and the MoH. The MOU awards CHAG member hospitals district hospital status and holds them accountable for fulfilling health service contracts, in exchange for which they receive support for salaries and other subventions. An addendum was added to the MOU in 2006, developing administrative instructions for implementation. Today, CHAG is recognized as an Agency with its own personnel by the MoH, parallel to the Ghana Health Service (GHS). In many ways, the collaboration between CHAG and the MoH represents a model that could inspire similar agreements in other countries.

Most of the information available on FIIs – and indeed, the basis for most of existing market share assessments – refers to CHAG facilities. There are, however, other faith-inspired providers who are not part of this network – although little is known about them. For example, among Islamic providers, the Ahmadiyya Muslim Mission (AMM) operates six hospitals in Kaleo (Upper West), Techiman (Brong Ahafo), Asokore and Kokofu (Ashanti), Swedru (Central), and Daboase (Western). The Ahmadiyya Muslim community also provides other health-related services including clinics, medical aid programs, and short-term health delivery projects (Salisu and Prinz 2009, Makinen et al

[2] In Ghana, faith-inspired providers are also commonly called 'mission-based providers' – and faith-inspired facilities are frequently classified as 'mission hospitals' – leading to some terminological challenges.

2011, Miralles et al 2003, Samwini 2006) as well as homeopathic medicine. Ahmadiyya appears to have few contacts with or support from the government, even if some of its hospitals function as district hospitals (Miralles et al 2003). Other Islamic initiatives are mentioned occasionally in the literature, such as a clinic run by the Islamic Republic of Iran (ICRO in Salisu and Prinz 2009). Yet overall, these other faith-inspired health care providers, whether Christian or Islamic, are small in comparison with those under the CHAG federation.

Given this context, we focus here on facilities associated with CHAG, and the purpose of this paper is to rely on administrative, household surveys, and qualitative data to answer three specific questions about the services provided by FIIs in Ghana: (1) what is the market share of faith-inspired providers as compared to other types of providers (section two of the paper); (2) are there differences in market shares among the poor between faith-inspired providers and other types of providers (this is also discussed in section two); and (3) how satisfied are patients with the services received, and why are patients choosing faith-inspired providers for care. The main conclusions are that estimates of the market share of FIIs from household surveys are at less than ten percent, versus 30 percent to 40 percent when using partial information on facilities data. The market share among the poor of FIIs appears to be similar to that of public providers, but higher than that of private non-religious providers. The reasons that lead patients to choose faith-inspired providers are not related directly to religion, but rather to the quality of the services provided, including values of dignity and respect for patients that the facilities exhibit.

MARKET SHARE AND REACH TO THE POOR

Estimates based on facilities data

In Ghana, the most commonly cited estimates of the market share of faith-inspired providers are based on hospital beds. Estimates from the Ministry of Health suggest that CHAG facilities provide 28 percent of all hospital beds. The total share of hospital beds among FIIs is 29.3 percent when Islamic facilities are added. However, the data on which these estimates are based are incomplete. Makinen et al (2011) found that data for private for-profit providers was particularly absent and that the data on the CHAG facilities was the exception, based on the stronger collaborative relationship between CHAG and the MoH. The other facilities tend to operate independently of the MoH, and are thus not included in current data gathering. This implies that the market share for both CHAG and public facilities tends to be overestimated, although it is not possible at this stage to assess how substantial this overestimation might be.

Table 1 provides a summary of other estimates of the share of faith-inspired providers in Ghana, as discussed in the literature. Most estimates of the market share of FIIs are in the 30 percent to 40 percent range. Some of the estimates are based on hospital beds, but others rely on outpatient care and the consumption of pharmaceuticals among others. For example, the Ecumenical Pharmaceutical Network (Annan and Essuman 2005) estimated on the basis of a survey on the consumption of pharmaceutical products by different types of facilities that faith-inspired providers accounted for about 40 percent of total

pharmaceutical consumption. Nimo and Wood (2005) suggested similarly that FIIs served around 40 percent of the population, supplying an estimated 30 percent of beds and 35 percent of outpatient care (quoted in Rasheed 2009). Marek et al (2005) suggested that 37 percent of inpatient admissions in hospitals (Accra excluded) were provided by CHAG, and CHAG has provided evidence that its hospital occupation rates tend to be higher than those of government hospitals (CHAG 2006). Previous statements and studies (see for example Miralles et al 2003) have yielded similar results. A few other studies, including older ones, are also included in Table 1, again with similar results. As a result of these various estimates, the MOU signed between CHAG and the government of Ghana explicitly stated that, *"This collaboration recognizes the pivotal role of the private health sector, which provides about 42 percent of Ghana's health care services and has been growing rapidly in recent times, as the engine of growth in the country's socio-economic recovery programme"* (Ghana-MoH and CHAG 2006).

Table 1: Selection of stated market share estimates for faith-inspired care in Ghana

Descriptive unit	Estimate	Source
Mission hospitals	50% outpatient care; >25% beds nationally, 46% in six under-privileged Northern regions	Bradley (in De Jong 1991)
Mission hospitals	(A third) 33% beds	World Bank 1993
Church	25% beds and 40% population served	Robinson and White 1998
Church hospitals	34% medical work	Matomora 1995
CHAG	Approx. 40% national health service	Green et al 2002
Catholic	27% share health care	Annan and Essuman 2005
Other Christian	11% share health care	
Muslim	1-2% share health care	
Mission facilities	40% pop., 30% beds, 35% outpatient care	Nimo and Wood 2005 (in Rasheed 2009)
CHAG	35-40% national health care	CHAG 2006
CHAG	25% NH Services	Dimmock 2007
Christian Health Networks	~34% of NHS (national health sector)	Chand and Patterson 2007
NFBHN (CHAG)	~34% NHS	Schmid et al 2008
Christian Health Services	40% NHS	Rookes 2010

Source: Compiled by authors

There is thus apparently considerable convergence in the existing estimates in the literature on Ghana, but this is not too surprising given that to a large extent, the estimates reflect the same reality – that is, data based on out-patient care as well as the consumption of pharmaceutical products tend to be very closely related to estimates of hospital beds because out-patient care and pharmaceuticals are used primarily by hospitals. The question is whether these estimates capture a large enough share of the total delivery of health care in the country. We would argue that interpreting the data in table 2 as valid estimates of the share of services provided by FIIs within the whole health system of the country is problematic for three reasons.

First, within formal care delivery mechanisms, a large share of health services are provided by other types of facilities than hospitals, such as clinics and health centers, as well as maternity homes and facilities from the government-run community-based health planning and services which are primary health care focused services sometimes with

mobile units. CHAG members primarily provide services through hospital facilities. For the year 2008, the share of district and other hospital facilities operated by FIIs was at 16.3 percent. But the share of all types of clinics operated by FIIs was much lower at 9.1 percent, and if one adds maternity homes and community-based health planning and services, the share of FIIs in all non-hospital facilities fell further to 5.5 percent. Overall, the share of FIIs in all types of facilities listed was at 6.6 percent. An analysis by Kissah-Korsah (2008) of more than 2,163 health institutions including most if not all of the CHAG facilities (the author identified 180 Christian facilities) suggests similarly that 53.5 percent of all facilities were governmental or quasi-governmental, with 38.0 percent being private non-governmental, and only 8.5 percent Christian facilities. Estimates of the market share of faith-inspired providers based solely on the number of facilities could also lead to underestimating the role of faith-inspired providers if only because hospitals tend to serve more patients per facility, but this still helps to put statistics on the number of beds into broader perspective.

A second issue with the reliance on statistics on hospital beds, pharmaceuticals, outpatient care and for that matter also the number of facilities is that a large share of health care is provided by other types of providers that are not included in such statistics. At least two different groups must be mentioned here. First, Ghana has a significant traditional sector that often operates alongside orthodox biomedical care, for example with patients mixing plural health-seeking modalities (Kissah-Korsah 2008, Van den Boom et al 2004). While studies on religion and health-related behaviors recognize the role of traditional practices, this is rarely addressed in the literature on FIIs. Some have suggested that in the roughly 25 years since the introduction of 'on the spot' payment for health delivery, more than half of the country's patients have turned increasingly to traditional health care and self-medication (Van den Boom et al 2004, Salisu and Prinz 2009). Second, self-medication has also been noted to be a significant practice – given the limited availability of doctors and pharmacists. There has been a trend towards the use of services provided by chemical stores especially. Self-medication has many potential dangers, including in terms of consumption of leftover and often expired drugs as well as untrained chemical sellers taking experts roles (Van de Boom 2004, see also Ballou-Aares et al 2008).

Data from the fifth round of the Ghana Living Standards survey (GLSS5) implemented in 2005-2006 help document the role of traditional healers and chemical stores. Nationally, it turns out that hospitals account for 31.6 percent of all consultations, followed by clinics that account for 28 percent of consultations. Both maternity homes and pharmacies have small markets shares. Traditional healers do not appear explicitly in this cut of the data, but their market share is somewhat limited (this group shows up primarily in the categories of providers identified as consultant's home, patient's home, and other.) By contrast, the role of chemical stores is very large, as they account for 29.4 percent of consultations, and an even larger share of consultations among the bottom quintiles (i.e. poorer segments) of the population, as is the case for other non-formal mechanisms of care delivery. In other words, on the basis of the types of care used in the country according to the GLSS5 data, the high market share of faith-inspired providers in terms

of hospital services would be somewhat diluted when considering a broader definition of the health sector.

Thirdly, it has been noted in many other neighboring countries, that faith-inspired as well as other community-based organizations tend to be engaged in a range of activities that stretch beyond formal health services. In the case of FIIs, this might be as a result of a 'holistic' focus on health – or because the FIIs (such as CHAG members) are commonly tied into broader developmental activities as a result of their ties to local communities and denominational bodies. Certainly in Ghana, the FIIs are involved in a range of 'development' activities, such as micro-financing and sanitation (De Jong 1991, Schmid et al 2008), and less formal community-based organizations play a large role in specific areas such as HIV and AIDS. But data on those community-based efforts are rarely available. All this to say that it is difficult to assess the scope and scale of community-based organizations and networks' health-related activities based on simplistic estimates of hospital bed market shares, or for that matter based on traditional household surveys.

Estimates based on household surveys

Market share estimates can also be obtained from household surveys, such as the GLSS5. The categories of providers in the GLSS5 are a bit different. In that survey, a first question is related to the type of facility used by households. A second question asks whether the facility is public, private-religious, or private non-religious. The market share of faith-inspired obtained from the survey is provided in table 2. It is estimated at close to 7 percent, almost reaching 8 percent when one excludes traditional healers and chemical stores. This is of course much lower than what is obtained on the basis of facilities data.

What could explain such different results? Much of the difference is likely to be as a result of the universe of health care being considered. If hospitals account for less than a third of all consultations in the GLSS5 data, assuming that hospital beds or outpatient care are good proxies for the overall supply of care of hospitals (which itself would be a strong assumption, given that a large share of hospital care does not necessarily require hospital beds), a hospital bed market share for faith-inspired providers of a third might be diluted into a market share of about 10 percent for health care as a whole (or slightly more when considering faith-inspired clinics as well) when a broader universe of care is taken into account, as is done in the surveys. This suggests that the household survey based estimates of market share may not be completely out of sync with the reality on the ground. Still, even then the survey-based estimates look small against the current wisdom of those working on the ground – for example those in the MoH or CHAG. An additional explanation might be that the identification of faith-inspired providers by households is partial only, with some households considering faith-inspired facilities as either private non-religious facilities, or with more likelihood as public facilities, especially when mission hospitals are considered as district hospitals and accordingly funded by the government.

Table 2: Share of patients by type of provider used, 2005-2006 GLSS5 (%)

	Residence Area			Welfare Quintile					Total
	Accra	Other urban	Rural	Q1	Q2	Q3	Q4	Q5	
	Including chemical, traditional providers, etc.								
Public	52.0	44.8	43.2	46.0	43.6	43.5	44.2	45.1	44.4
Private religious	3.9	7.8	6.4	7.0	5.5	7.1	6.6	6.8	6.6
Private non-religious	44.1	47.5	50.5	47.0	50.9	49.4	49.3	48.2	49.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Excluding chemical, traditional providers, etc.								
Public	55.1	64.0	63.2	69.2	65.3	62.8	64.3	57.2	62.5
Private religious	4.2	8.7	8.0	6.3	6.4	8.9	7.6	8.4	7.8
Private non-religious	40.8	27.3	28.9	24.6	28.3	28.3	28.2	34.4	29.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Authors' estimation using GLSS5 2005-2006 survey

Apart from this stirring up the debate on market share, is the question of whether some types of providers reach the poor better than others, as this relates directly to efforts by the government to adapt the entire health system so that it better serves rural and marginalized areas. Here again, the common perception is that faith-inspired providers play a special role vis-à-vis the poor, in part because of their preferential option for the poor, and its corollary of faith-inspired services and facilities being physically located in marginalized areas. As CHAG (2006) put it, "*CHAG members cater for an estimated 35-40 percent of the national population, mainly in the hard to reach rural places in Ghana.*" Or as De Jong (1991) argued, faith-inspired services tend to be *"…particularly represented in poorer, more remote areas out of commitment to serve the under privileged (e.g., religious missions often state this explicitly) or because they can fill a gap in such areas not already met by government services. In Ghana, for instance, while missions provide 25 percent of total hospital beds in the country, they provide about 46 percent of beds in the six under-privileged northern regions (Bradley 1989 in De Jong 1991)…Missions tend to be disproportionately represented in the less privileged areas."*

The same argument is made almost thirty years later by Ballou-Aares et al (2008) who suggest that *"the public sector channel is most active in more densely populated areas, which are also relatively more affluent. The faith-inspired channel is an important source of health care to less affluent or poor people in far-flung areas…geographic access for less affluent people in rural areas is a problem with access being limited to the southern part of Ghana."* Serving marginalized areas was certainly the intention of many faith-inspired providers when facilities were set up. However, current evidence on whether faith-inspired facilities today still reach the poor proportionately more than other types of providers is thin, as this is difficult to establish relying solely on facilities data limited for the most part to hospitals and clinics.

Because household surveys include data on the socio-economic characteristics of households, they can be used to assess which facilities reach various segments of the population classified according to their level of well-being. In the GLSS5, well-being is measured according to the level of consumption per equivalent adult. Importantly, even if some faith-inspired providers are misclassified in the surveys, to the extent that the likelihood of such misclassification is similar for all faith-inspired facilities, this should

not affect substantially estimates of the extent to which various types of facilities reach the poor. Consider the case where faith-inspired providers serve the poor more than other providers in the specific sense that the share of their services obtained by the poor is higher than is the case for other providers. If some faith-inspired facilities are misclassified by households as public facilities in a quasi-random way (the probability of misclassification is similar for all faith-inspired facilities), then the share of the beneficiaries that are poor in faith-inspired facilities would not be affected. As for public providers, the erroneous inclusion of some faith-inspired providers in their pool would lead to a higher share of beneficiaries of public facilities identified as poor than warranted, but the bias should be small because the number of faith-inspired facilities misclassified as public facilities would be small as a proportion of the total number of public facilities. This is because the market share of faith-inspired facilities is smaller than that of public facilities, and because only a subset of faith-inspired facilities would be misclassified. In addition, if it turns out that the profile of beneficiaries according to level of well-being is similar between faith-inspired and public facilities, the bias would even be smaller.

The data in table 2 suggest relatively few differences between public and faith-inspired facilities in terms of whether they reach various segments of the population according to level of well-being, but substantial differences with private non-religious facilities, as would be expected given that these facilities tend to be more expensive. Specifically, according to the GLSS5 data, faith-inspired providers do have a higher market share in rural than in urban areas. As to whether faith-inspired providers have a higher market share among the poor, the proportion of patients relying on faith-inspired providers seems slightly lower in the bottom than in the top quintiles (as a proportion of the overall demand for care among those groups), but the differences are not very large. Thus, it would be fair to suggest that according to the results from the survey, faith-inspired providers do not necessarily have a proportionately higher market share among the poor than among better off households than is the case for the government (the public provider) – but of course, faith-inspired providers do reach patients from poor households.

It must be noted that the estimates provided in table 2 are estimates of the market shares of various providers within population groups, such as households grouped according to their level of consumption. The estimates show that the market share of FIIs in the various quintiles is similar across quintiles, as is the case for public facilities. This can be interpreted as showing that FIIs and public facilities comparatively reach the poor in a similar way. But it does not mean that both types of facilities serve the poor and better off households equally. As discussed in Coulombe and Wodon (2012a) in their benefit analysis of public health spending in Ghana, households from the top quintiles of consumption benefit from a much larger share of the health services provided by both public and FIIs facilities than households in the bottom quintiles. That is, *both* public and FIIs facilities serve the poor less well than they serve the better off (see also Coulombe and Wodon 2012b on the geographic location of FIIss).

PERFORMANCE

Existing studies

Detailed comparative data between faith-inspired-, public-, and other private providers of health services are for the most part not available in Ghana. It is most difficult to compare FIIs against the other private providers such as other NGOs or for-profit providers. Makinen et al (2011) have recently completed a mapping assessment of the private health sector in Ghana, and note that there is still no comprehensive data on the size and configuration of the private sector, with the exception of CHAG – whose closer relationship with the MoH means that there is slightly more known about CHAG than the other private providers. Certainly there is not nearly enough available data to embark on a more comprehensive comparative of equitable access to health care (availability, affordability and acceptability). What remains then are stand-alone comparatives, providing individual pieces to the broader puzzle that is the Ghanaian health system, and one of the objectives of the papers in this collection is precisely to start conducting more in-depth work on comparing public, private religious, and private non-religious health care providers.

On the basis of admittedly incomplete data, it can be seen that based on some measures FIIs seem to be doing slightly better than public providers, while in other areas they may be doing slightly less well. As a first example of comparative analysis, consider the statistics provided in Table 3. The table shows that CHAG district hospitals had on average higher occupancy rates in their facilities than public hospitals. This might reflect a preference on the part of the population in using FIIs (as also suggested by Shojo et al 2012), better management, or simply location advantages. While location advantages tend to be historically driven, other explanations would suggest higher performance by CHAG in this specific area.

Table 3: Beds and Occupancy Rates in CHAG and Public District Hospitals, 2006

	Western	Central	Greater Accra	Volta	Eastern	Ashanti	Brong Ahafo	Northern	Upper East	Upper West
	Number of Beds									
CHAG	474	387	67	967	930	1,084	1,119	324	253	336
Government	756	678	683	1,137	1,180	932	252	340	575	493
	Occupancy Rates (%)									
CHAG	74.9	61.9		43.2	56.6	51.4	57.5	57.8	53.1	42.0
Government	46.5	44.0	47.8	43.8	44.2	44.5	62.5	57.7	45.0	46.1

Source: CHAG (2006).

As a second example of comparative assessment, consider the data on the pricing of medicines provide in Table 4 from META Ghana (2009). The data suggests that the prices of various drugs tend to be slightly higher in the rural faith-inspired sector than in the rural public facilities. For four out of seven drugs, the prices in FII facilities were more than ten percent higher than those in public facilities. For two of the drugs, the prices were more than ten percent higher in public facilities, while for the last drug, the differences in prices were below ten percent. This suggests on average that drug prices in FIIs are slightly higher in FIIs than in public facilities. This also appears to extend to patient prices more generally. Miralles et al (2003) suggested that patient prices in FIIs

were on average twelve percent higher than in the public sector. Makinen et al (2011) find that out-of-pocket spending by patients at CHAG facilities is higher than at private and public providers. However, they also note that *"lower price as a provider attribute is most frequent among CHAG providers*" – suggesting that while out-of-pocket costs might be higher at CHAG facilities, the public perception may well be that they are lower. This is discussed in more detail in the Shojo et al (2012), but it is important to note that this may have changed in recent years with the adoption of the National Health Insurance Scheme which has substantially reduced out-of-pocket costs overall.

For the most part, comparative based only on the cost for patients of pharmaceuticals suggests slightly better performance for the public sector (in terms of lower costs for patients), although some of the broader issues that affect the sector as a whole should not be obscured by the somewhat limited differences between FIIs and public facilities. Indeed, it has been suggested that in general, the price of pharmaceuticals may be too high in Ghana. The MoH, as cited in Salisu and Prinz (2009) stated that *"A comparative study of medical procurement by the MoH and the faith-inspired health sector…showed that it would take approximately four wage days for a person to purchase medicines from the private sector and almost three from the mission sector…the study also found out that beside many complications such as change of prices with change of deliverer, both government and missions often had to buy at more than double the market procurement prices"* (Salisu and Prinz 2009).

Table 4: Comparison of drug prices by sector (2007/2008)

	Inter-national reference Price (GHC)	**Rural Mission Sector (median price)**		**Rural Public Sector (median price)**		**Rural Private Sector (median price)**		**NHIS reimbursement prices**	
Medicine name	IRP	Median Price (GHC)	Ratio to IRP	Median Price (GHC)	Ratio to IRP	Median Price (GHC)	Ratio to IRP	Reimbursed prices 2008 (GHC)	Ratio to IRP
Ciprofloxacin	0.0292	0.2000	6.84	0.1750	5.98	0.1700	5.81	0.2	6.84
Clotrimazole	0.0077	0.1650	21.51	0.0584	7.61	0.1075	14.02	0.16	20.86
Diclofenac	0.0055	0.0350	6.40	0.0400	7.32	0.0300	5.49	0.1	18.30
Mebendazole	0.0156	0.4750	30.39	0.3500	22.40	0.7000	44.79	1.2	76.79
Phenytoin	0.0048	0.0800	16.69			0.1000	20.86	0.06	12.52
Quinine Injection	0.0768	0.1175	1.53	0.2500	3.26	0.1250	1.63	0.28	3.65
Ranitidine	0.0229	0.1200	5.24	0.1250	5.46	0.1000	4.36	0.2	8.73

Source: META Ghana (2009).

As a third example of analysis aiming to compare the practices and performance of FIIs versus public and other private facilities, Annan and Essuman (2005) use a baseline survey carried out as part of a project to improve access to essential medicines for FIIs and their clients. The study found that the overall trend for FIIs in Ghana was one of improvement. They note Ghana has a well-functioning drug supply system, and relatively high numbers (at least in comparison with other African countries) of pharmacists, pharmaceutical technicians, and pharmaceutical assistants per hospital. Yet the study also revealed differences between FIIs and other providers. The study suggested that at a

national scale, FIIs tended to have *lower* drug prices for patients than other providers (the difference from the studies mentioned earlier may be related to the fact that the study by Annan and Essuman was national in scope), they also tended to rely on drug sales revenues more than other providers to cover their costs, and they tended to have more difficulties in managing their stocks of drugs. FIIs also did not have established rational drug use policies.

The above three studies on comparative performance suggest some differences between FIIs and public facilities, but these differences tend to be small, and not always consistent between studies. It is likely that with the further integration of CHAG facilities in the national health system that has taken place over the last few years, some of the differences between FIIs and public facilities may have been reduced further. What is clear though is that both FIIs and public facilities struggle with common problems such as a shortage of qualified staff, a high cost of inputs, limited cost recovery which affects financial sustainability, and increased competition from other private providers. Such competition is observed not only for patients, but also for staff. Yet before turning to these problems, it is necessary to consider the relationship between CHAG and the government, and how it has evolved, especially during the last decade.

Other existing studies

Recent qualitative data collected by Shojo et al (2012, in the second volume of this collection) from fieldwork among staff and patients in six FIIs in two locations in 2010 provide more insights into the performance of FIIs, as well as the reasons why patients rely on their services. A few results from that study are worth summarizing here. The data revealed that patients using FIIs were satisfied with the quality of staffs, hygiene in the facilities, and cost (which are now lower thanks to the NHIS), but less so with the availability of proper accommodation, technical equipment, and medicines. The situation was more difficult for clinics and hospitals not yet accredited with the new NHIS (National health Insurance Scheme) being implemented since 2004, probably in part because this resulted in higher costs for patients.

More precisely, quality of care was the main reason for choosing facilities according to the qualitative fieldwork. Among patients in Christian clinics/hospitals, two thirds said that quality was the main reason for choosing the clinic/hospital, and close to sixty percent mentioned that workers are skilled, knowledgeable, competent, dedicated, and patient; in short they appreciated the quality of the staff. For patients in Islamic clinics/hospitals, the most common answer was the quality of workers followed by the quality of service, with location coming third. Respect for patients came in strongly as a key reason for choosing FIIs. *"Here we are treated with respect. They listen to us well and understand all of our problems. They take their time to talk to us in a polite way. You don't regret spending your money at this hospital. Even if they don't have all the equipment, the way they handle makes me feel comfortable"* (Female Muslim patient, Islamic clinic); *"I have heard that they are a top quality hospital and they are very serious with their work and they treat patients with care and respect"* (Male Christian patient, Christian hospital).

To get at the reasons for choosing providers differently, patients were asked to share the advantages that they see in using FIIs. In Christian facilities a third of patients cited "quality of workers" as the main advantage of the facilities, followed by "assistance for the poor" (25 percent of respondents) and "quality of service" (19 percent). Among patients in Islamic facilities, the most common answer was "worker's skills and quality" (44 percent) followed by "location" (31 percent). Two other reasons were mentioned: "Assistance for the poor/orphans" and "quality of service" by 12.5 percent of respondents. The availability of assistance for the poor, while not a leading criterion for the choice of provider, was also mentioned by facility staff. As a Director at an Islamic clinic explained, *"What is the target population of this clinic? Elders come, youth come, children come, and pregnant women come… any kind of category. The majority of people who come to this clinic are Moslem, but we have non-Moslem too. They are Christian or believe traditional religion. Also we have both poor and somehow middle income group. Majority of the patients are actually poor. That is one of main reason of establishment of this clinic. People are facing financial problems, unemployment and deprivation. Their monthly income is low. We try as much as possible to subsidize our services.*"

By contrast, few patients mentioned religion as determinant or deterrent for choosing FIIs. This is apparent in answers provided to questions shown in table 5, and it emerges also from interviews: *"I am Christian but came to this Islamic clinic not because of my religious beliefs but because the clinic works well"* (Female Christian patient, Islamic clinic); *"I will seek health care from even a Christian health facility if that is of high quality but not go to a traditional priest"* (Male Muslim patient, Christian clinic); *"My religious beliefs do not affect my choice of health care for me and my family. I am Moslem and I have been attending a Catholic clinic in the past, so religion doesn't matter to me. Any clinic where I can receive effective medical care, I will go"* (Male Muslim patient, Islamic clinic). Most patients had no problem in using services provided by FIIs from a different faith: *"If they will take good care of me to get well, I don't care what faith is behind them"* (Male Christian patient, Christian hospital); *"I use Islamic clinic here even though I am Christian because I believe that it is providing gravity health care and not about changing me to Moslem"* (Male Christian patient, Islamic clinic). When patients mentioned values or faith, this was done typically in general terms and in a positive way: *"As an Islamic community this clinic is seen as a good model of what Islam can do for Moslems. It is providing health care as well as spiritual care for the people"* (Male Muslim patient, Islamic clinic); *"They try to increase the faith of patients who come to this clinic, so it is good. It boosts the moral of patients and increases their faith. Even though I am Moslem, I like it so much"* (Male Muslim patient, Christian clinic).

Table 5: Patients' values and choice of health care provider, 2010

Questions	Patients who use a clinic that belongs to a different religion	Patients who use a clinic that belongs to the same religion
Do your religious beliefs and values affect your choices regarding healthcare?	Yes: 0 %	Yes: 10.8%
Are you willing to use health care services at a clinic which is grounded in a faith different from your own?	Yes: 100%	Yes: 89.1%
Do you think that the health clinic/hospital should provide spiritual guidance and counseling to the patients?	Yes: 18.1%	Yes: 33.3%

Source: Shojo et al. (2012).

The desire to serve communities as a whole without specific reference to faith of patients also emerged from interviews with FII staff. *"We serve all mankind. We accept patients who belong to different religion. The vision of the national catholic health services is to provide high quality health care in the most effective, efficient and innovative manner, specific to the needs of the communities we serve and at all times acknowledging the dignity of the patient"* (Director of a Christian facility). *"There was no clinic around here before. We established this clinic to assist poor community in this area. Most of the people in this area are Moslem, but our target population is entire community. We accept everyone…Personally I am Christian, but I am working at Islamic clinic as a doctor. I don't care the patients' religion. Whatever they believe, we are fighting for our own goal to support the people's health*" (Doctor at an Islamic clinic).

CONCLUSION

The objective of this paper was to answer three questions. Firstly, what is the market share of FIIs as compared to other types of health care providers in Ghana? Existing estimates based on administrative data on hospital beds suggest that FIIs account for 30 to 40 percent of health care provision, but estimates from household surveys are at less than 10 percent. Existing estimates are likely to be biased upward because they rely on hospital beds (or related measures such as outpatient care and the consumption of pharmaceuticals), a sub-sector where faith-inspired providers have traditionally been especially active. But this ignores large segments of health care provision, including smaller health facilities, traditional healers, as well as pharmacists and chemical stores, some of which have grown substantially in recent times. Estimates of the market share of FIIs based on household surveys may well be underestimated, in part because some faith-inspired facilities may have been considered by households as public facilities given that in many districts, faith-inspired hospitals serve as district hospitals.

The second question was: do FIIs reach the poor proportionately more than other types of provider? The household survey data suggests that the market share of FIIs among the poor is similar to that of public providers, and higher than that of private non-religious providers who tend to have a higher market share among better off segments of the population. Thus faith-inspired and public providers appear to be serving the poor roughly equally to public providers, while private providers tend to serve more the higher socio-economic groups than either faith-inspired or public providers. This does not mean

however that FIIs and public providers serve all segments of the population equally. Most health care facilities continue to serve the better off more than they do the poor, in that the share of services received by poorer segments of the population is much smaller than their population share.

The third question was about the level of satisfaction of patients with the services received from FIIs, and the motivation for choosing faith-inspired providers. Qualitative data collected in 2010 in six facilities by Shojo et al (2012) suggest that the satisfaction with the services received in faith-inspired facilities is high, including in areas such as respect paid to patients. Subjective satisfaction does not measure quality per se, but it is an important indicator and it appears indirectly from the qualitative data that faith-inspired facilities may have a comparative advantage at least in terms of the attention paid to patients. More data would be needed to confirm this, but it is encouraging for faith-inspired facilities. It also appears that faith-inspired facilities try to help the poor afford the cost of care. Finally, and this is also related to the question of quality, religion itself does not seem to be a direct factor for the choice of faith-inspired facilities. Many patients use services from clinics and hospitals that are affiliated with a different faith from their own, and the main reason for the choice of facility is precisely the perception that they provide services of quality. This of course raises questions about the indirect impact of religion or faith on quality of care.

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