Do faith-inspired health care providers in Africa reach the poor more than other providers?

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DO FAITH-INSPIRED HEALTH CARE PROVIDERS IN AFRICA REACH THE POOR MORE THAN OTHER PROVIDERS?

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Faith-inspired institutions (FIIs) commonly have as their stated mission a desire to provide quality health services to all, and in particular a commitment to serve the poor, for example, by providing services in remote areas where there are none, or by making services more affordable for those in need. Yet it is unclear whether they are able to fulfil this commitment in the current contexts in which they operate – for example by serving the poor proportionately more than other (wealthier) households, or being utilized by the poor more than other providers. Using data from 14 recent nationally representative household surveys in Africa, this paper suggests that when compared with public providers on a broad macro scale, FIIs currently tend to serve the poor slightly less than other population groups. The data also suggest that on average, beyond differences between countries, FIIs do not serve the poor proportionately more than public providers (the most relevant comparison, given that non-religious for-profit private providers tend to be more oriented towards serving wealthier groups). This does not mean that FIIs do not make special efforts to reach the poor, for example by subsidizing them in order to make services more affordable. However, it suggests that in current African health contexts, FIIs may no longer be that different from public providers in the clientele they serve.

INTRODUCTION

It is now common to state that faith-inspired institutions (FIIs) contribute a large share of health care services in Africa. Alongside such market share estimates, a strong argument is also made that FIIs have characteristic comparative values, including a preferential option for the poor - in particular, providing services to the 'rural poor' where there might otherwise be none. For example, in a World Bank working paper, De Jong (1991) describes health-engaged non-governmental organizations (NGOs) working in Africa. She notes, "*…NGOs including missions, involved in health-related activities tend to be particularly represented in poorer, more remote areas, either 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…NGO activities may also be concentrated in areas that the government is not serving for political reasons…There is debate, however, on the extent to which NGOs really do reach the poor or the underserved…"* More recent examples can be seen in the current documentation of the various Christian Health Associations (CHAs) in Africa. For example, in the 2006 Memorandum of Understanding (MOU) between the Government of Ghana's Ministry of Health and the Christian Health Association of Ghana (CHAG), a shared purpose is expressed to improve health services in Ghana, *"…especially at the rural and deprived communities where CHAG facilities are situated by choice, and*

experienced in serving such communities, in line with their Christian mission of service to the poor, marginalized and disadvantaged." Furthermore, the MOU is based on the common principles that, while the Government of Ghana is generally responsible for the provision of health needs of the population as a whole, "*CHAG institutions, in line with their Christian teachings, shall target service provision to the poor and the marginalized in the society*" (Ghana-MOH and CHAG 2006, more examples below).

Unfortunately, while the sentiment that FIIs target the poor in their health and education service provision is shared across Africa and internationally, the evidence of what is happening in practice is rather thin, mostly anecdotal, and at times outdated. This is especially the case for claims that FIIs target the poor in a preferential way - which are made strongly in a wide variety of literature, but for which there appears to be little robust comparative data.

The question of whether FIIs in Africa reach the poor preferentially begs a clarification – as there are a number of different questions intertwined within these common perceptions about faith-inspired health services. One question is to what extent FIIs serve the poor 'proportionally more' than other population groups internally, that is among their clientele. Another question is whether FIIs serve the poor proportionally in comparison to other providers such as other private or public facilities. It also may be useful to consider whether FIIs employ special strategies to serve the poor (for example, by cross-subsidizing their services – either within a particular facility, or across a system of facilities). It has also been broadly suggested that FIIs serve the poor primarily as a result of their choice of location in remote rural areas where there are no other health providers – begging the question of how their comparative service to the poor is related to their physical location. These are all different and important questions for policies aiming to make health care more accessible and affordable to vulnerable groups, but again the literature to-date has provided only very limited information on each of them.

The objective of this paper is to begin to engage with this complex collection of issues by addressing only the first two questions mentioned above. First, is the share of the poor in the clientele of FIIs higher than the share of other household groups? Second, are the services provided by FIIs used by the poor proportionately more than the services provided by other health care providers? To answer these two questions, we rely on data from 14 recent nationally representative household surveys in Africa, with health questionnaire modules sufficiently detailed to permit the identification of faith-inspired providers among the various types of health care providers that households rely upon for their care (see also Wodon 2013).

The paper is structured as follows. Section two provides a brief review of the literature, both on the role of FIIs in health care provision in Africa generally, and specifically addressing the understanding that FIIs serve the poor in a preferential way. Section three presents new evidence from the household surveys to look at these questions.

REVIEW OF THE LITERATURE

Health services and care provided by faith-inspired institutions and communities are 'significant' in many countries in Africa. In the colonial period, mission-based hospitals and primary care were a dominant source of healthcare provision in many areas – with colonial governments implementing differently organized health service strategies, some focused on providing services to European employees of the colonial state (primarily in urban areas), and others through Christian missions providing health and educational services to indigenous populations (see Robinson and White 1997, Schmid et al 2008).

Different national strategies were adopted after independence as countries dealt with the legacies of their respective colonial administrations. "*This included centrally funded health systems, operating out of new national capitals with little local accountability. In time, funding from colonial powers in Europe was replaced by United Nations (UN) agencies and more recently, by other donors*" (Schmid et al 2008). In some countries faith-inspired health facilities built in colonial times remained dominant despite attempts at imposed controls of the voluntary sector (such as in Tanzania, Zambia, Kenya and Malawi). Other countries integrated these facilities more fully into public systems, as was the case in South Africa. As to the classic provision of healthcare through 'church health facilities', it was bolstered in many countries by a rapid growth of civil society organizations (often supported by international funders) that become engaged in health and development work, creating a complex landscape of non-state, private, or non-profit health provision.

Furthermore, in sub-Saharan Africa (SSA), the HIV/AIDS response has had a significant impact on the role of FIIs, with a rapid growth of actors (of the NGO variety) being formed around the year 2000 (see Haddad et al 2008). This particular historical trajectory related in part to the creation of new funding sources contributed to make the involvement of faith-inspired civic institutions in health and health-related service provision especially significant in SSA, and perhaps more so than in any other region in the world.

While it may be safe to describe the 'significance' of faith-inspired health care, putting a number or estimate to that significance is much more challenging. One challenge is that faith-inspired health services are rarely properly aligned with national health systems, with faith-inspired, private and public health sectors developing in parallel to each other in many countries. The idea that FIIs own a large portion of the health infrastructure has resulted in talk of there being a 'faith sector' which is a 'hidden giant' in Africa – but this is most often stated with the caveat that integration of FIIs into national health systems and large development programmes is still lacking (see Asante 1998, Schmid et al 2008).

In the last two decades there has been a resurgence of interest in non-state and faith-inspired health service provision. This came as a result of several factors, such as growing recognition of the lingering importance of religion to African communities, an increased focus on community-oriented development and health engagement, reforms of national health sectors, an increased focus on the 'public-private mix' of health services,

and health sectors looking to better harmonize activities and strengthen increasingly fragile and resource-constrained health systems (see Hanson and Berman 1994, Schmid et al 2008). There has also been a burst of interest from governments and international agencies, which have begun to ask if the presence of FIIs can be more clearly demonstrated and mapped, so that they might become stronger allies in the delivery of health services and the accomplishment of global targets – which has generally resulted in increased collaboration (see Marshall and Keough 2005, Olivier and Paterson 2011).

However, the evidence as to the role of FIIs in healthcare in Africa remains weak. As Hanson and Berman (1994) put it, "*much of what we know is based on anecdotal evidence and ad hoc data collection…There is considerable diversity within the continent, both with respect to levels of expenditure and orientation of health system.*" This may be in part as a result of a complex history of secularization and modernization theories and academic tendencies, the 'faith sector' became largely invisible, so that while the work of faith-inspired institutions continued, these activities were either hidden from view, or in a few cases, subsumed as part of private, non-state or civil society sectors. As a result, good data are frequently absent, incomplete or stored in protected nodes – for example, with different institutions conducting separate inventories that are often not made publicly available, or utilizing different measures that prevent this information from being comparable and integrated. The evidential landscape is also slanted heavily towards large and organized FIIs with an international or national footprint; towards particular mainstream denominations (with less coordinated faith-inspired groups such as the Pentecostals or 'traditional' groupings getting significantly less attention); and towards Anglophone countries which tend to have a larger footprint for FIIs as well as a more developed descriptive literature, written in English (see Schmid et al 2008).

The huge diversity of the so-called 'faith-sector' also presents many challenges for evidence gathering – with diversity of religious profile across regions, of types of FIIs and services differently engaged in health and development work. As many have noted, this diversity makes any broad regional generalisations dangerous. There is no international inventory or map of faith-inspired health services or facilities, and national and international mapping projects often do not include FIIs who have flown 'under the radar' for decades, and remain invisible to national and international views as well as unaligned with national health systems (see ARHAP 2006, Marshall and Van Saanen 2007, Schmid et al 2008, WHO-CIFA 2009). As World Bank President James Wolfensohn (now famously) said in 2002, "*half the work in education and health in sub-Saharan Africa is done by the church…but they don't talk to each other, and they don't talk to us*" (in Kitchen 2002).

In the context of this poor evidence-based, it is still frequently stated that a key 'comparative advantage' of FIIs is that they manage to reach the poor - whether this is done by providing services at lower cost for patients, or being located in poor, often rural areas. Examples of statements that combine 'market share' estimates with the notion that FIIs primarily serve the poor are given in Table 1 for a subset of countries and for sub-Saharan Africa as a whole.

Table 1: Statements on market share and reach to the (rural) poor of FIIs in Africa

Country	Statement	Sources
Burundi	In Burundi more than one third of health services in rural areas are provided by mission clinics	Hanson and Berman 1994, World Bank 1983
Ghana	In Ghana while missions provide 25% of total hospital beds in the country, they provide about 46% of beds in the six under-privileged northern regions; CHAG members cater for an estimated 35-40% of the national population, mainly in the hard to reach rural parts of Ghana	De Jong 1991, CHAG 2006
Kenya	The majority of Christian Health Association of Kenya (CHAK) member health facilities are located in rural and remote marginalized areas of the country	Muriithi et al 2007
Malawi	The Christian Health Association of Malawi (CHAM) manages 171 health facilities in mainly remote rural areas across the country. This makes up 37–40% of all health facilities in Malawi and particularly responds to the need for health facilities in some remote areas with little government coverage	Ward et al 2010, CHAM 2008
Nigeria	The Christian Health Association of Nigeria strives to deliver healthcare to the furthest and most remote parts of Nigeria (where most member facilities are positioned), reaching out to those who would otherwise not benefit from health care…providing 40% of health services with a special emphasis on the needs of the rural poor	CHAN 2006
Senegal	In Senegal, most private sector facilities are located in and around Dakar as well as a few large towns … the major exception is the health posts operated by the Catholic Church, most of which are in rural areas	Knowles 1994
Tanzania	The Christian Social Services Commission (CSSC) estimates that FBOs in Tanzania manage 40% of hospitals, 26% of all health facilities and provide 50% of health services in rural areas	CSSC 2007, Todd et al 2009
Zambia	The Christian Health Association of Zambia (CHAZ) accounts for nearly 30% of Zambia's total health care provision in general and 50% of rural health care provision	Nussbaum 2005, Mogedal and Steen 1995, Robinson and White 1998
Zimbabwe	Zimbabwe church missions provide 68% of all beds in rural areas; In Zimbabwe 80%, and in Tanzania 90%, of church hospitals are in rural areas initially less favored by other health care providers	Green and Matthias 2005, Robinson and White 1998, Gilson et al 1994
Africa	(In SSA) health services are often concentrated in urban areas while rural areas, where most of the population lives, are underserved. Mission hospitals and health care centers are frequently the only such services to be found in these areas	Parry 2003

Source: Compiled by the authors.

All of these examples suggest that FIIs are located in poor and marginalized areas and serve primarily the poor. Many experts (from faith-based and secular positions) are ready to defend such a perspective of FIIs based on their experience in the field. If correct, such assertions should have serious implications for policy, since stakeholders should be more inclined to support FIIs, especially for provision of health care to those with limited access. However, it is difficult to unpack the data on which these statements are based – especially considering the acknowledged dearth of national-scale inventories or maps inclusive of faith-inspired health facilities. There are unfortunately few systematic

surveys that can verify such statements, certainly not in a way that could be used to engage with specific policies and strategies that address particular characteristics of faith-inspired service provision. This demonstrates the importance of moving beyond broad statements about the 'faith sector' provision in Africa, to evidence-based information that can have a more profound impact at a policy level (see Olivier and Wodon 2012). Said differently, market share estimates that are inclusive of specific indicators which can demonstrate access for the poor and contributions to higher equity in health care seem much more likely to have an immediate impact at a policy level. If these FIIs are indeed the only available facility in specific area, or are targeting a specific poor population, then a different strategy is required for their support.

General statements that FIIs in Africa are targeting the 'rural poor' are not likely to have much effect without more robust evidence – especially in the complex health service contexts as in Africa. Mission facilities were historically located in both isolated areas, as well as urban centers (see Gilson et al 1994, Schmid et al 2008). Contexts have changed, with some facilities falling into disrepair, and in other locations FIIs have taken up abandoned government facilities in remote areas (Banda et al 2006). McGilvry noted in 1981 that the location of FIIs was often "*determined more by ecclesiastical considerations and historical circumstances than by an analysis of health needs. As a result there was frequent overlapping and duplication*" – however it is difficult to know whether such 'ecclesiastical' considerations still hold sway, or quite what the criteria for the location of FII services currently are. Most African countries now have diverse and migratory populations, where the 'rural poor' is just as likely to be located in urban centers. FIIs have also moved and adapted, with many more NGOs (faith-inspired or not) working in areas not served by the traditional mission facilities. It is also suggested that FIIs are more frequently located in conflict areas than other providers, with faith-inspired staff motivated to remain in such contexts as a result of their faith (see Lusey-Gekawaku 2003).

Another concern with any broad statement about the preferential option for the poor by FIIs is the always problematic broadness of the category of 'FIIs' (or FBOs) – especially given the historic diversity of faith-inspired health providers. For example, a common over-simplification is that all (or even most) mission-based health facilities were historically located in remote rural areas serving only the poor. Of course, many were, but there were also large faith-inspired facilities established in 'urban' centers, providing high quality services to all, including the 'non-poor'. This demonstrates the difficulties in making sweeping statements about all FII's preferential provision to the poor – especially when such statements are substantiated mainly by pointing to the geographic location of facilities (which is varied), without a better understanding of the nature of clientele served, or the mechanisms employed to subsidize service to the poor.

There has also been a rapid expansion over the last twenty years in the number of public facilities operating in poor areas, and to a smaller extent the same trend is also likely to have taken place in at least some countries for non-profit health facilities operated by non-religious NGOs. This is because many countries have significantly expanded the provision of services through health posts or clinics in rural areas, while at the same time

the network of facilities operated by FIIs such as the Christian Health Associations have often continued to be oriented towards service provision through larger facilities such as hospitals (which do not reach all poor areas of a country, and are by nature rarely 'pro-poor'). Thus, the more rapid expansion of non-religious facilities in poor areas may have eroded some of the significance of the location-based edge that FIIs may have had in serving the poor (being reminded that we are considering here the comparative presence of FIIs at a macro-level as considered by policy-makers, rather than the acknowledged value of individual FIIs providing health services in remote and hardship areas).

Furthermore, even faith-inspired facilities which were historically established in remote or rural areas, may no longer find themselves serving their originally intended population. The demographic landscape of many countries has changed so much in terms of urbanization and (at least in some countries) poverty reduction in the last 20-30 years that it is no longer clear that the original facilities still operated by FIIs are now mostly located in poor rural areas in many African countries. For example, in a number of countries, FIIs used to be located in coastal areas, but these are the areas that have developed the most in most African countries over the last few decades, and these are also the areas where poverty has been reduced the most. These evolving poverty geographies mean that many FIIs must now reconsider what it means to 'serve the poor'. Certainly, the broader discourse about FIIs in Africa seems to be stuck in a pattern describing the 'faith sector' focus on the 'rural poor' – when, in fact, there is a broad re-articulation of this core ethos being enacted. For example, in their annual report of 2006, CHAG demonstrates some of these shifts necessitated by changed circumstances, saying: "*CHAG member institutions are located predominantly in the rural areas and are aimed at reaching the marginalized and poorest of the poor. A few are in big towns now but were built there when the towns were small and rural. A few can now also be seen in the slumps of some of the cities. These are targeted at serving the health needs of the poor and vulnerable populations that have been created by urbanization*" (CHAG 2006).

All such considerations need to be clarified – and the possibility of preferential service to vulnerable groups seems an important place to begin. More provision should also be made for consideration of location, population served, access or availability vis-à-vis other providers. It is not clear whether the 'significance' of faith-inspired healthcare is underestimated or overestimated – especially if such issues are not pulled into prominence. Some of these questions may be answered by improved service availability mapping being undertaken by the World Health Organization (WHO) over the next decade.[1] However, at this time, despite a strong stated perception by a wide variety of actors, there is currently little 'hard evidence' that *overall*, FIIs in Africa today reach the poor more than other providers in relation to their geographic location in poor areas.

The fact that the provision of healthcare to the rural poor is a core ethos of most FIIs is not what is called into question here. For example, in Uganda it has been noted that: *"The faith-base of the (private-not-for-profits) was regarded as a distinguishing*

[1] The WHO SAMS questionnaire has recently been updated so that it contains a more precise count for faith-inspired facilities and services. The results of these updated surveys are likely to become available over the next 5 to 10 years.

characteristic…These values translated…into explicit commitments to serve low-income communities. Thus, some of the agencies assessed by the study included special mention of meeting the needs of the most vulnerable in their mandates" (Schmid et al 2008). Reinikka and Svensson (2010) also argued on the basis of data from a quasi-experiment in the provision of untied block grants to health centers in Uganda, that faith-inspired providers appear not to be motivated by profit or perks maximization, but rather by a desire to make more of their services available and affordable to the poor - that is, they seem to be 'working for God.' Uganda is only one example of where there are clear demonstrations of the *desire* of FIIs to serve the poor. What is still not clear is whether FIIs are able to fulfill this desire to provide preferential option for the poor – in their current contexts which are often influenced by the demands of alignment with national health systems, competition with private for-profit providers, and the concerns around financial sustainability in the resource constrained environments in which they all operate.

Indeed, the commitment to serve the most vulnerable has created a core dilemma for FIIs operating in modern health sectors: when their 'mission' to serve the poor and marginalized seems to sometimes come into direct conflict with the financial survival of the organization (see Olivier and Wodon 2012). For countries with a very low per-capita income it is extremely difficult to maintain high quality health services that are accessible and affordable for the poor. This faith-motivated ethos is not just a value or organizational characteristic, but impacts directly on financial decisions. For example, many FIIs have developed complex user fee systems based on an 'ability to pay' principle - where some patients are charged at a full cost in order to subsidize the healthcare of poorer patients (see Banda et al 2006, Gilson et al 1994). This is a critical time in the history of health-providing FIIs, as they are being pushed to weigh their organizational culture and reason for being, against the realities of financial support and survival, *"it is a challenge that cuts to the heart of the religious-health landscape, arguing that if FBOs do have the unique strengths listed above, a 'value added', then now is the time to consider just what that value added is 'worth' and therefore, in what ways it is to be supported"* (Schmid et al 2008) – before it is lost.

EVIDENCE ON BENEFIT INCIDENCE

At this time, nationally representative household survey data in which households are asked about the type of health care facility they use when seeking care have not been extensively drawn into these discussions about the extent to which FIIs reach the poor. As noted by Olivier and Wodon (2012) in discussing the market share of FIIs, this may be in part because the surveys most frequently used for work on health and development, the Demographic and Health Surveys (DHS) implemented in similar ways in most African countries at regular intervals, do not distinguish between faith-inspired and non-religious providers of care; they only distinguish between public and private providers, often suggesting that private providers provide a large share of all care in Africa, but this does help answer the questions raised above.

The fact that household surveys have not been used more extensively for such work is surprising given that this method may gather more robust and nationally representative socio-economic profiles of health service users (these are, for example, the surveys that are used for poverty measurement). For this paper, instead of using DHS data, we assessed the availability of data identifying faith-inspired health providers in the main multi-purpose surveys implemented in approximately 30 African countries. In about half of the surveys that we looked at, there was enough information on the type of provider consulted by households to identify separately public, private non-religious, and private faith-inspired providers. The list of those surveys and countries is provided in table 2. Note that in Ghana, we have two different and independent household surveys at our disposal – we will thus report for that country the average values obtained with the two surveys taken together.

Table 2: Selected countries with household surveys identifying FIIs

Country (survey name)	Year of implementation	Country (survey name)	Year of implementation
Burundi (QUIBB)	2006	Niger (ENBC)	2007
Cameroon (ECAM)	2007	Nigeria (LMS)	2003/04
Chad (ECOSIT2)	2003/04	ROC (QUIBB)	2005
Ghana (CWIQ and GLSS5)	2003 and 2005/06	Senegal (ESPS)	2005
Kenya (KIHBS)	2005	Sierra Leone (SLIHS)	2003
Malawi (HIS-2)	2004	Swaziland (SHIES)	2009
Mali (QUIBB)	2006	Zambia (LCMS IV)	2004

Source: Compiled by the authors.

In a separate paper, we used the same data to look at the market share of FIIs – a method which results in significantly lower estimates than is commonly obtained from the comparison of facilities data (Olivier and Wodon 2012). However, in that discussion we also note a possible underestimation of the market share of FIIs in the population as a whole when it is based on household survey data in this way. However, this does not affect the analysis of the extent to which FIIs reach the poor in the same way. 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 still significantly smaller than that of public facilities, especially when one considers non-hospital care, 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 be even smaller.

In addition, as mentioned in the introduction, the question of whether FIIs in Africa reach the poor proportionately more than other providers begs some clarification: proportionally more than other population groups (internally, among their clientele) or proportionally more pro-poor in comparison to other providers such as other private or public facilities? These are really two different questions. In what follows, we rely on the systematic use of the fourteen household surveys mentioned in table 1 to answer the two questions, but we will also make additional reference to other work, including that which is qualitative in nature.

Consider first the question of whether internally, among their own clientele, FIIs serve more socio-economically disadvantaged patients. This can be investigated in a partial way in terms of the location of facilities, given that the extent to which FIIs reach the poor is likely to partially depend on this. While we do not do this here, it is worth noting that in the case of Ghana for example, the data suggests that FIIs are not significantly more present in poorer areas than in better-off areas (Coulombe and Wodon 2011). Yet it could be that when relying on the location of facilities, we are not clearly seeing how FIIs might be providing preferential option for the poor, even located in less-poor areas, because of data gaps on who is served by whom within districts. This is where the household survey data becomes useful.

In table 3, data are provided as to the share of the users of services provided by FIIs belonging to various quintiles of well-being, with each quintile accounting for twenty percent of the population, from the poorest to the richest.[2] Although poverty estimates vary between countries, in most countries the bottom two or three quintiles can be considered as representing the poor. The evidence from the fourteen countries suggests that for the most part, FIIs do not serve the poor proportionately more than wealthier groups. The data actually suggest that on average the clientele of FIIs tends to be less poor than the population as a whole, probably in large part because many FIIs operate hospitals and clinics, and care provided in these types of facilities tends to be more expensive and less accessible to the poor than care provided in smaller health posts (also, the larger the facility, the more likely it is that it will be located in an urbanized area with lower levels of poverty). In addition, many among the poor simply do not seek care when ill or sick because they cannot afford the cost of care. This means that the share of households who seek care in higher quintiles of well-being is often larger than in lower quintiles. Of course, this does not mean that FIIs do not make special efforts to reach the poor or to make care more affordable for them. But due to the nature of the service that they provide and the broader socio-economic constraints faced by the population when seeking care, even if such efforts may indeed succeed in reaching some among the poor, overall the services provided by the facilities are not typically 'pro-poor'.

There are, however, some differences between countries. For example, Cameroon and Swaziland appear to be countries where the use of facilities operated by FIIs in the top

[2] The quintiles are based on measures of consumption per capita or per equivalent adult normalized by poverty lines accounting for differences in cost of living between areas within a country, in order to ensure consistency with poverty measurement techniques.

quintile is twice that in the bottom quintile, and in Nigeria, the differences are even larger (although we trust this data for that specific country less due to the low market share observed for FIIs in the survey, which seems to be more at odds with the facilities-based estimates of market share than is the case in the other countries). By contrast, in the Republic of Congo, FIIs seem to serve the poor proportionately more than wealthier groups in the population. Note that in the case of Mali, the pattern is a bit erratic, essentially because the sample size for estimating the benefit incidence of the services provided by FIIs is rather small. If one were to exclude the outlier value of 2.8 percent benefit incidence in the top quintile for that country, the average share of services obtained by the wealthiest quintile for the remaining thirteen countries would be 24.2 percent, similar to what is observed for the fourth quintile.

Table 3: Benefit incidence by quintile of well-being of services provided by FIIs (%)

	Q1 (Poorest)	Q2	Q3	Q4	Q5 (Richest)	All
Burundi	17.6	20.9	18.6	22.5	20.4	100.0
Cameroon	13.9	16.0	19.9	24.0	26.2	100.0
Chad	23.0	22.8	19.5	17.0	17.7	100.0
Ghana	21.5	18.3	19.9	20.0	20.5	100.0
Kenya	12.8	21.9	12.3	28.5	24.5	100.0
Malawi	10.5	15.0	19.9	25.7	28.9	100.0
Mali	27.1	13.1	16.7	40.3	2.8	100.0
Niger	8.9	13.2	49.8	13.5	14.7	100.0
Nigeria	8.0	9.8	11.3	17.7	53.3	100.0
Republic of Congo	31.8	19.5	7.0	22.7	19.1	100.0
Senegal	19.0	11.5	18.1	37.1	14.3	100.0
Sierra Leone	13.4	20.9	13.4	26.2	26.2	100.0
Swaziland	13.2	17.2	15.9	27.6	26.0	100.0
Zambia	21.0	18.5	15.3	22.1	23.1	100.0
Average	17.3	17.0	18.4	24.6	22.7	100.0

Source: Authors' estimations using household surveys.

However, are FIIs comparatively more pro-poor than public or other private facilities? A simple way to answer that question is to compare the market share of FIIs in the various quintiles of well-being as well as in the population as a whole, as done in table 4. Note that in table 4, non-religious private providers are a highly heterogeneous group that includes fairly different types of providers, from for-profit hospitals and clinics which tend to serve the wealthier segments of the population to chemical stores and pharmacists, as well as informal health practitioners such as traditional healers who serve the poor more (among traditional healers, some could be considered as faith-inspired, but that is not an obvious call, and for the specific purpose of this paper which focuses more on assessing facilities-based services provided by FIIs, it seems more appropriate to exclude traditional healers from FIIs).

On average, and when looking at the average market share across the fourteen countries provided in the last row of the table (without using population weights to reflect the size of each country and the market share of FIIs in each country), the profile of the market share by quintile of faith-inspired facilities is similar to that of public facilities. There are relatively few differences in market shares between the first four quintiles, but the market share of both faith-inspired and public facilities drops a bit in the top quintile, essentially

reflecting the higher use of modern non-religious private health facilities in that group. The market share of FIIs in the poorest quintile is however proportionately slightly higher than is the case in the public sector, but besides that, differences are small. The fact that there are few systematic differences in the market shares of FIIs between quintiles suggests that in comparison to public providers, the reach to the poor of FIIs is somewhat similar. Thus, FIIs serve the poor slightly less than other groups, as was shown in table 3, but this is also the case for public providers on average. When one considers the market share of FIIs in the various quintiles, it does not change much, showing that *FIIs do neither much better, nor worse than public providers, but they do a slightly higher market share among the very poor.*

As before, there are of course differences between countries. In Chad for example, the market share of FIIs among households from the poorest quintile, at 14.8 percent, is twice as large as that among the richest quintile, at 7.0 percent, and there is clear indication that the market share declines once one considers richer segments of the population. Thus, in Chad, FIIs serve the poor proportionately more than other providers. In Malawi, at least according to the survey estimates, the reverse is observed: the market share of FIIs is higher among wealthier household than it is among the poor. In table 4, there are three countries where FIIs tend to serve the poor slightly more than all other providers on average, three countries where the reverse is observed, and in the other countries, the conclusion is typically not clear-cut.

The conclusion that emerges from the data in table 4 is that in terms of market share, FIIs do not seem to serving the poor proportionately more than the public sector, except perhaps in the bottom quintile of well-being, but even there the evidence is limited.

Table 4: Market share of FIIs among households groups by quintile of well-being (%)

	Public providers						Faith-inspired providers						Private non-religious providers					
	Q1	Q2	Q3	Q4	Q5	All	Q1	Q2	Q3	Q4	Q5	All	Q1	Q2	Q3	Q4	Q5	All
Burundi	69.3	69.7	68.0	69.3	70.1	69.3	11.8	14.1	10.7	11.2	10.2	11.5	18.9	16.2	21.4	19.6	19.7	19.2
Cameroon	42.2	42.9	44.2	46.2	47.3	44.9	14.6	13.3	15.1	16.9	15.3	15.1	43.3	43.9	40.7	36.9	37.5	40.0
Chad	45.9	50.6	62.5	58.4	58.7	55.8	14.8	14.4	11.5	8.4	7.0	10.7	39.3	35.1	26.0	33.2	34.3	33.5
Ghana	43.9	43.4	43.6	44.2	43.8	43.8	6.1	4.7	5.4	5.2	5.0	5.2	50.1	52.0	51.1	50.7	51.4	51.1
Kenya	53.3	47.8	53.0	50.2	41.7	49.0	3.1	5.1	2.6	5.4	4.7	4.2	43.6	47.1	44.4	44.4	53.7	46.8
Malawi	40.2	40.9	36.0	34.4	34.5	36.9	2.6	3.0	3.7	4.4	5.5	3.9	57.2	56.2	60.3	61.2	60.1	59.1
Mali	56.1	69.4	72.6	77.4	66.4	69.4	2.1	0.8	1.0	1.7	0.1	1.0	41.8	29.8	26.5	20.9	33.5	29.6
Niger	55.3	44.4	44.1	54.9	52.7	50.3	0.9	1.2	3.6	1.0	0.8	1.5	43.9	54.4	52.3	44.2	46.5	48.2
Nigeria	58.1	53.0	56.5	54.1	42.8	50.2	2.3	1.5	1.1	1.4	2.7	1.9	39.7	45.5	42.4	44.5	54.5	47.9
Republic of Congo	40.4	43.9	44.8	44.7	46.1	44.0	7.1	3.0	4.0	2.7	3.5	4.0	52.5	53.1	51.2	52.6	50.4	52.0
Senegal	61.8	65.0	69.2	68.2	62.1	65.0	2.3	2.1	1.9	4.2	1.3	2.3	36.0	32.9	28.9	27.6	36.6	32.7
Sierra Leone	60.9	64.1	60.8	62.1	57.4	60.1	9.3	8.5	6.7	7.5	3.8	6.1	29.9	27.5	32.5	30.4	38.8	33.8
Swaziland	79.0	75.5	72.3	64.3	52.4	66.4	15.0	12.2	10.7	15.8	12.5	13.2	6.0	12.3	17.1	19.9	35.1	20.5
Zambia	58.5	54.4	59.3	54.2	51.4	55.0	8.9	6.8	5.1	5.9	5.2	6.2	32.7	38.8	35.7	39.9	43.3	38.8
Average	54.6	54.6	56.2	55.9	52.0	54.3	7.2	6.5	5.9	6.5	5.5	6.2	38.2	38.9	37.9	37.6	42.5	39.5

Source: Authors' estimations using household surveys.

When combined with the evidence provided on benefit incidence, it therefore does not seem valid to claim that in general, all FIIs serve primarily the poor, or that they do more so than the public sector, even if they do serve the poor more than other non-state (and non-religious) service providers. In fact, because many FIIs are at least in part privately funded (now often partially subsidized by the state), the fact that they serve the poor more than other non-state, non-religious facilities-based providers is a positive and important achievement which certainly deserves more attention – however this a rarely acknowledged nuance in the literature which broadly claims a special reach to the poor for all FIIs.

It should be clear that the analysis presented in this paper has limits, and no simple conclusion about FIIs' reach to the poor in Africa should be removed from this discussion. Benefit incidence analysis or market share comparisons between providers are not the only indicators that can be relied upon to assess whether FIIs serve the poor in a preferential way. Another indicator could be that of the cost of service – even if FIIs do not serve the poor proportionately more than public providers, and even if they tend to have (slightly) more patients from wealthier than poorer backgrounds, it could be that FIIs make special efforts to make their services more affordable to the poor. There is some partial evidence to that effect for several of the countries detailed above. In Ghana for example, detailed analysis of the private cost for households of health care suggests that FIIs may indeed be subsidizing the cost of care for the poor (Coulombe and Wodon 2011). In Burkina Faso, on the basis of in-depth qualitative work in six clinics, Gemignani et al (2011) suggest that a key reason for individuals to seek care in FIIs is the fact that the cost of care is lower than in public facilities (the other reason being that faith-inspired facilities appear to provide better quality of care). The ability of FIIs to make good quality care affordable for the poor is maintained in the clinics through support in kind and in cash from religious groups and donors. Still, considering in a systematic way the ways in which FIIs may manage to make their services more affordable to the poor is beyond the scope of this paper, and before making any general statement on cost and affordability, more research is needed.

CONCLUSION

There is substantial diversity today in how FIIs provide care in African countries, and whom they serve. FIIs might often aim to serve all – but they also usually have an explicit commitment to providing preferential option for the poor and the vulnerable. The extent to which they are actually able to do so in their current resource-constrained environments remains an open question. What household survey data suggests is that, as is the case with other facilities-based providers, FIIs actually tend to serve the poor less than other population groups, most likely in part because cost (and in some cases distances to facilities) still represents major obstacle to care for the poor. The data also suggest that on average, although there are differences between countries, FIIs do not serve the poor proportionately more than other providers, or at least than public providers (given that, as expected, non-religious for-profit private providers tend to be more oriented towards wealthier groups). This still does not mean that FIIs do not make special efforts to reach the poor, for example by subsidizing them in order to make services more

affordable for them. But beyond anecdotal evidence, systematic data to back up that specific claim is still not readily available.

These results, which point to a more limited reach to the poor among FIIs than is commonly stated in the broad literature, should not cast doubt on the intention or desire of many FIIs to reach the poor. But FIIs face a number of constraints, in terms of their location, cost recovery mechanisms, and in many cases rules governing national health systems. As FIIs are becoming more integrated in such systems, a difficult choice may have to be confronted. Whether FIIs should consolidate their current services, or whether they should (and can afford to) institute changes to direct their energies to again prioritize the poor is unclear. This type of decision is also linked to other important decisions that have to be made by FIIs, for example, prioritizing primary health care versus facilities-based care. In any case, such reflections challenge us to push beyond broad, advocacy-oriented statements as to whether FIIs in Africa reach the poor proportionately more than others – towards more operational and practical questions, such as what could be done to help FIIs fulfil their desire to serve the poor more.

In addition to statistical evidence, more research is needed in order to better document and learn from the multiple initiatives that are being enacted by FIIs to better their reach to the poor. This is especially important if a case is to be made that FIIs require additional or special support from national and international policy-makers. Again, as public health services are (in some places) being expanded into more poor areas and FIIs are often increasingly incorporated in national health systems, these questions and initiatives become critical. What does a core commitment to the poor mean (operationally) in the context of our current health systems? In settings where FIIs play an especially important role, such as in fragile states with very low per-capita income levels, how can they maintain high quality health services that are accessible and affordable for the poor? What data and evidence needs to be gathered (by the FIIs themselves and others) to demonstrate these priorities? Such questions should drive future investigations.

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