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DIFFERENCES IN THE PRIVATE COST OF HEALTH CARE BETWEEN PROVIDERS AND SATISFACTION WITH SERVICES: RESULTS FOR SUB-SAHARAN COUNTRIES

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The issue of whether faith-inspired providers are able to reach the poor depends in part on the cost of the health services provided. This paper relies on recent nationally representative household surveys for sub-Saharan African countries to assess to what extent the cost of healthcare is a major reason for not being satisfied with health services and whether concerns with costs differ between types of providers. The paper also provides estimates of the cost of healthcare in a half dozen countries, again comparing public, private secular, and faith-inspired providers. The results suggest that cost indeed remains a major concern for households. There are differences in out-of-pocket costs for households between providers, with in many cases public providers being cheaper than faith-inspired providers and private secular providers. Yet these differences depend on the country and are not as large as one might have assumed.

INTRODUCTION

Whether faith-inspired providers are able to reach the poor depends in part on the cost of the health services that they provided. It is often believed that faith-inspired providers in Africa do reach the poor in part because they make special efforts to make their services affordable to them at low cost. This concern for the poor and the affordability of care is itself related to the fact that Africa's two leading religions, Christianity and Islam, both have longstanding traditions of service to the poor, including in the area of healthcare.

There is some evidence that faith-inspired health facilities have altruistic motives, or at least do not behave in the way that for-profit health providers would, and this has implications for cost recovery of the services provided. In their analysis of health service provision in Uganda, Reinikka and Svensson (2010) used a change in financing of not-for-profit health care providers through untied grants to test two theories of organizational behavior. The first theory postulates that not-for-profit providers are intrinsically motivated to serve the poor and will therefore use new resources to expand their services or cut the cost of these services. The second theory postulates that not-for-profit providers are captured by their managers or workers and behave like for-profit actors. Although they may not appropriate profits, they would tend to use untied grants to raise the salaries of their staff or provide them with other benefits that would not directly serve the poor. The authors' empirical results suggest that the first altruistic theory is validated by the data, and that the results matter in the sense that this altruistic difference makes a difference for the poor. Specifically, the authors were able to show that untied grants made to small faith-inspired facilities were used to increase services and reduce costs for patients, as opposed to increasing benefits for staff.

Yet as this example also implicitly suggests, the extent to which faith-inspired health providers are able to make their services affordable for the poor depends on their funding and other resources in comparison to those of other providers. In order to be able to provide quality services at low cost to the poor, faith-inspired providers must benefit from appropriate resources, for example through support from congregations, whether these are locally based or located in developed countries, or from other organizations including government agencies. In the absence of such support, subsidies granted to the poor may require charging better off patients more for the services provided to those groups, or relying on staffs that are willing to work at below market wages.

Different strategies for reducing the cost of services for the poor may not have the same medium- or long-term consequences. For example, relying on staffs who are willing to work at below market wages (as may be the case for nuns for example), or on resources made available by external groups may not carry a risk in terms of financial sustainability as long as the staffs are willing to continue to work for low wages or as long as external funders are willing to continue to provide resources in order to make services more affordable for the poor. By contrast, differentiated subsidies for the poor paid for by asking higher fees from other groups – what could be referred to as a Robin Hood strategy - might not be sustainable under competitive markets. Indeed, under competitive markets, subsidies for the poor would lead not only to poor patients or students relying on faith-inspired facilities as compared to other facilities, but also to fewer non-poor patients or students, which would ultimately be unsustainable in the absence of other funding or cost reduction mechanisms, such as those mentioned earlier. It might be feasible under different types of markets to charge more to the better off in order to subsidize the poor – for example, under a segmented market with quality differentiated among others according to faith, better off households who value the faith affiliation of a clinic may be willing to pay more at that clinic than at another clinic, which may then make it feasible for a facility to subsidize the services provided to the poor. Yet it is not clear how much resources might be generated through price differentiation for such purposes.

In this paper, we do not discuss specifically how faith-inspired facilities may be able to make their services affordable for the poor, whether this is done through cross-subsidization or through access to resources from congregations and other donors (for a case study on this question, see Gemignani et al 2012; see also more generally Wodon 2013). Instead, and more simply, we first assess in section 2 to what extent the cost of healthcare remains a major reason for not being satisfied with the health services received by households and whether concerns with costs differ between different types of providers. Thereafter, we estimate in section 3 the private cost of healthcare in a half dozen countries and compare out-of-pocket costs between public, private secular, and faith-inspired providers. Finally, we provide a brief country case study in section 4 on how health sector reforms may help in providing more equity in the financing of health facilities and reduce out-of-pocket costs for households. A brief conclusion follows.

IMPORTANCE OF COSTS FOR HOUSEHOLDS

Is the private out-of-pocket cost of healthcare a major issue for households? In order to answer this question, we build on the analysis of patient satisfaction with faith-inspired and other service providers presented in Volume two of this series by Olivier and Wodon (2012). The results presented in that chapter suggested that satisfaction with the services provided by faith-inspired providers was higher than with those provided by public facilities. Using the same data, this section shows that one of the main reasons for non-satisfaction with the services received among households is related to the cost for households of the services. Yet at the same time, there are also substantial differences between countries, with cost being more of an issue in some of the poorest countries.

The analysis is provided in tables 1 through 5 for five countries where the data are available through specific questions in the survey questionnaires. In the tables, the first line accounts for the share of households who were satisfied with the services received. The other lines represent the main reasons for not being satisfied. The responses (satisfaction and reasons for non-satisfaction) sum to 100 percent within each group (i.e., national, urban-rural, and quintiles of well-being) as well as for the various providers.

In all countries, the fact that the cost of service was perceived as too expensive is the main reason for lack of satisfaction. Cost is mentioned as an issue for 37.9 percent of patients in Burundi (the poorest country in the sample), 18.0 percent in Senegal, 13.1 percent in Mali, 11.4 percent of patients in Ghana, and 10.4 percent in the Republic of Congo (the richest country in the sample). In Mali and Burundi (the two poorest countries in the sample) but not in the other three countries, cost is also mentioned more by households in the bottom quintiles of well-being, which does make sense.

What is also interesting is the fact that in four of the five countries, cost is actually mentioned as being less of an issue for faith-inspired facilities than for public facilities. In the Republic of Congo, 14.6 percent of patients in public facilities declare that cost is an issue, versus 6.5 percent in faith-inspired facilities. In Burundi, the two corresponding figures are 37.9 percent for public facilities, versus 30.6 percent for faith-inspired facilities. In Mali, the comparison is 16.9 percent to 6.0 percent. Finally in Senegal 19.6 percent of users of public facilities complain about cost, versus only 2.9 percent in faith-inspired facilities. For Ghana by contrast, the proportion of users who complain about cost is similar in both types of facilities (it is actually slightly higher in faith-inspired facilities at 14.4 percent versus 13.2 percent in public facilities), but this is also the country where there are no substantial differences in overall satisfaction rates between public and faith-inspired providers. Note that in three of the five countries, complaints about cost were higher in other private facilities than in the faith-inspired sub-sector. The comparison with private facilities is however more complex because many households going to private facilities may have formal insurance that reduce out of pocket costs.

Table 1: Satisfaction rates and reasons for non-satisfaction in Burundi (%)

	Residence Area		Welfare quintile					Total
	Urban	Rural	Q1	Q2	Q3	Q4	Q5	
Public								
None (satisfied)	46.6	37.8	36.8	35.5	37.5	35.1	44.0	38.0
Facilities were not clean	0.6*	1.6	0.6*	0.7*	0.6*	2.2	3.1	1.6
Long waiting time	6.7*	11.9	10.8	10.0	11.5	14.7	11.4	11.8
No trained professionals	2.3*	1.3	1.1*	2.0*	1.1*	1.0*	1.7*	1.4
Too expensive	35.1	38.0	41.3	40.6	37.9	39.7	31.6	37.9
No drugs available	2.2*	3.3	3.7	3.7	4.2	3.3	1.9	3.3
Treatment unsuccessful	1.1*	4.5	5.0	4.8	4.5	3.1	4.7	4.4
Prison	1.9*	0.0*	0.0*	0.0*	0.0*	0.1*	0.1*	0.1*
Other	3.5*	1.6	0.6*	2.7	2.7	0.9*	1.5	1.7
Faith-inspired								
None (satisfied)	47.4	43.1	46.6	43.7	34.6	48.1	42.6	43.2
Facilities were not clean	0.0*	0.6*	0.0*	0.0*	0.6*	1.7*	0.5*	0.6*
Long waiting time	7.1*	17.0	18.5	18.4	17.1	10.8*	18.9	16.7
No trained professionals	0.0*	0.5*	0.0*	0.0*	1.9*	0.5*	0.0*	0.5*
Too expensive	38.4	30.3	29.0	30.7	39.2	32.7	21.7	30.6
No drugs available	2.7*	2.6	1.8*	3.1*	2.2*	2.8*	3.2*	2.6
Treatment unsuccessful	1.3*	4.8	2.7*	3.9*	2.5*	1.9*	12.1*	4.7
Prison	-	-	-	-	-	-	-	-
Other	3.1*	1.1*	1.4*	0.4*	1.8*	1.5*	1.0*	1.2*
Private secular								
None (satisfied)	47.7	39.3	34.9	41.8	43.3	35.9	43.2	40.0
Facilities were not clean	0.0*	2.4	1.1*	1.5*	0.8*	5.9*	0.9*	2.2
Long waiting time	2.2*	7.7	10.9*	5.4*	5.6*	8.1	6.6	7.3
No trained professionals	0.5*	1.1*	3.9*	1.0*	1.0*	0.0*	0.2*	1.0*
Too expensive	41.6	42.6	39.2	47.1	42.1	42.9	42.0	42.5
No drugs available	3.4*	2.0	2.5*	1.3*	2.2*	2.6*	1.8*	2.1
Treatment unsuccessful	1.9*	3.7	5.7*	0.7*	3.5*	3.3*	4.0*	3.5
Prison	-	-	-	-	-	-	-	-
Other	2.7*	1.3*	1.9*	1.1*	1.5*	1.2*	1.3*	1.4*
All users								
None (satisfied)	47.3	38.6	37.6	37.6	38.3	36.7	43.7	39.0
Facilities were not clean	0.3*	1.7	0.7*	0.7*	0.8*	2.9	2.6	1.7
Long waiting time	4.8	11.8	11.8	10.4	10.9	13.0	11.1	11.5
No trained professionals	1.5*	1.2	1.5*	1.5*	1.2*	0.7*	1.3	1.2
Too expensive	38.1	37.9	39.4	40.3	38.9	39.5	32.6	37.9
No drugs available	2.8*	3.0	3.2	3.3	3.6	3.1	2.0	3.0
Treatment unsuccessful	1.5*	4.3	4.9	4.0	4.0	3.0	5.3	4.2
Prison	0.9*	0.0*	0.0*	0.0*	0.0*	0.1*	0.1*	0.0*
Other	3.1*	1.5	1.0*	2.1	2.4	1.0*	1.4	1.6

Source: Authors' estimations using household surveys.

Note: * indicates less than 20 observations – these cells are likely not to be reliable but provided for completeness.

Table 2: Satisfaction rates and reasons for non-Satisfaction in Ghana, 2003 (%)

	Residence Area		Welfare quintile					Total
	Urban	Rural	Q1	Q2	Q3	Q4	Q5	
Public								
None (satisfied)	73.4	73.2	70.6	75.7	75.0	73.0	72.1	73.3
Facilities were not clean	1.0	0.8	0.8	1.2	0.8	0.5	1.0	0.9
Long waiting time	8.3	5.7	5.8	5.6	6.2	7.9	8.0	6.8
No trained professionals	1.1	1.2	1.6	1.3	1.0	1.0	1.0	1.1
Too expensive	13.8	12.8	13.1	12.4	11.8	13.7	14.6	13.2
No drugs available	7.0	5.7	7.1	5.3	5.6	5.9	7.3	6.3
Treatment unsuccessful	5.6	8.5	10.1	6.8	6.7	5.9	7.3	7.2
Poor staffing attitude	2.5	1.9	2.0	1.8	1.7	2.3	2.7	2.2
Other	0.2	0.4	0.4	0.3	0.4	0.3	0.2	0.3
Faith-inspired								
None (satisfied)	73.1	72.9	67.2	76.0	74.3	73.0	74.4	72.9
Facilities were not clean	0.1	0.4	0.0	0.8	0.3	0.1	0.4	0.3
Long waiting time	6.1	6.0	8.1	3.6	5.3	3.6	9.0	6.0
No trained professionals	1.3	1.6	0.7	2.1	1.2	2.9	0.7	1.5
Too expensive	17.6	13.1	17.3	12.0	14.9	14.0	13.4	14.4
No drugs available	3.9	3.9	4.3	2.5	3.0	4.6	4.9	3.9
Treatment unsuccessful	6.3	8.4	10.6	8.5	7.1	9.2	4.0	7.9
Poor staffing attitude	1.2	2.2	2.0	2.5	3.1	1.0	1.4	1.9
Other	0.6	0.4	1.0	0.2	0.9	0.0	0.3	0.5
Private secular								
None (satisfied)	83.2	83.8	83.2	85.7	84.3	82.5	82.3	83.5
Facilities were not clean	0.3	0.2	0.3	0.2	0.3	0.3	0.2	0.2
Long waiting time	2.0	0.9	0.7	1.0	1.0	1.6	2.1	1.3
No trained professionals	0.4	0.3	0.3	0.2	0.2	0.5	0.4	0.3
Too expensive	11.9	8.1	7.6	7.5	9.1	11.4	11.6	9.7
No drugs available	3.6	2.6	2.5	2.0	2.6	3.9	3.6	3.0
Treatment unsuccessful	3.2	7.0	8.3	5.7	5.1	4.6	4.4	5.4
Poor staffing attitude	0.5	0.8	0.8	0.5	0.5	0.8	0.8	0.7
Other	0.2	0.2	0.2	0.1	0.1	0.3	0.3	0.2
All users								
None (satisfied)	78.5	78.9	77.2	81.0	79.9	78.0	77.8	78.7
Facilities were not clean	0.6	0.5	0.5	0.7	0.5	0.4	0.5	0.5
Long waiting time	4.9	3.1	3.2	3.1	3.4	4.4	4.8	3.9
No trained professionals	0.7	0.7	0.8	0.7	0.6	0.8	0.7	0.7
Too expensive	12.9	10.3	10.4	9.8	10.5	12.5	12.9	11.4
No drugs available	5.1	3.9	4.5	3.4	3.9	4.8	5.2	4.4
Treatment unsuccessful	4.3	7.7	9.2	6.3	5.9	5.3	5.6	6.3
Poor staffing attitude	1.4	1.3	1.4	1.1	1.1	1.5	1.6	1.4
Other	0.2	0.3	0.3	0.2	0.3	0.3	0.2	0.3

Source: Authors' estimations using household surveys.

Note: * indicates less than 20 observations – these cells are likely not to be reliable but provided for completeness.

Table 3: Satisfaction rates and reasons for non-satisfaction in Senegal (%)

	Residence Area		Welfare quintile					Total
	Urban	Rural	Q1	Q2	Q3	Q4	Q5	
Public								
None (satisfied)	71.1	57.8	67.1	65.8	58.5	63.2	65.9	64.0
Staff not welcoming	2.1	2.9	1.5	1.1	3.6	3.2	2.5	2.5
Facilities were not clean	1.2	1.1	0.9	0.7	1.3	1.2	1.4	1.1
Long waiting time	9.2	16.3	8.0	8.8	15.7	14.9	14.7	12.9
No trained professionals	2.2	4.5	2.5	2.1	4.9	4.5	2.7	3.4
Too expensive	12.6	25.7	17.0	16.3	23.8	21.7	18.0	19.6
No drugs available	4.5	6.8	3.2	5.1	6.5	6.7	6.1	5.7
Treatment unsuccessful	3.2	9.6	8.6	8.4	6.6	6.8	4.2	6.6
Other	1.3	10.3	3.7	4.9	5.8	7.6	7.0	6.1
Faith-inspired								
None (satisfied)	86.9	86.6	92.8	86.2	79.3	85.9	90.9	86.8
Staff not welcoming	0.0	0.1	0.0	0.4	0.0	0.0	0.0	0.0
Facilities were not clean	2.4	0.0	0.0	0.0	0.0	0.0	8.1	1.2
Long waiting time	4.8	5.2	3.7	3.6	10.7	5.2	0.0	5.0
No trained professionals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Too expensive	1.8	3.9	1.4	0.4	8.5	2.7	0.0	2.9
No drugs available	3.8	4.0	1.4	4.0	0.0	8.2	1.0	3.9
Treatment unsuccessful	0.0	2.9	2.4	6.9	1.5	0.0	0.0	1.5
Other	1.5	1.2	2.4	0.4	0.6	1.9	0.0	1.3
Private secular								
None (satisfied)	71.9	66.1	66.7	64.1	65.4	70.9	74.0	69.2
Staff not welcoming	2.9	1.0	0.6	0.7	2.0	3.6	2.4	2.0
Facilities were not clean	0.8	0.7	1.2	0.3	0.5	0.8	0.7	0.7
Long waiting time	7.1	5.1	5.1	6.6	5.4	5.4	7.3	6.1
No trained professionals	0.9	3.9	1.8	2.5	5.2	1.8	1.2	2.3
Too expensive	15.3	16.9	14.7	18.7	16.9	15.7	15.4	16.1
No drugs available	2.5	5.3	4.7	6.5	3.7	2.6	2.7	3.8
Treatment unsuccessful	4.7	10.4	11.7	9.5	6.6	5.8	5.4	7.4
Other	1.2	7.0	5.3	5.7	5.9	3.5	1.5	3.9
All users								
None (satisfied)	71.8	61.0	67.7	65.6	61.0	66.3	69.2	66.2
Staff not welcoming	2.3	2.2	1.2	1.0	3.0	3.2	2.4	2.3
Facilities were not clean	1.1	1.0	1.0	0.5	1.1	1.0	1.3	1.0
Long waiting time	8.3	12.6	6.9	8.0	12.6	11.8	11.8	10.5
No trained professionals	1.7	4.2	2.2	2.1	4.9	3.6	2.1	3.0
Too expensive	13.3	22.5	15.8	16.8	21.5	19.2	16.8	18.0
No drugs available	3.7	6.3	3.7	5.5	5.5	5.6	4.8	5.0
Treatment unsuccessful	3.7	9.7	9.6	8.7	6.4	6.3	4.6	6.8
Other	1.2	9.1	4.3	5.1	5.7	6.2	4.9	5.3

Source: Authors' estimations using household surveys.

Note: * indicates less than 20 observations – these cells are likely not to be reliable but provided for completeness.

Table 4: Satisfaction Rates and Reasons for non-Satisfaction in Rep. of Congo (%)

	Residence Area		Welfare quintile					Total
	Urban	Rural	Q1	Q2	Q3	Q4	Q5	
Public								
None (satisfied)	68.0	62.1	69.6	68.0	60.6	63.3	67.3	65.7
Staff not welcoming	6.5	14.4	11.0	11.6	7.9	9.6	8.9	9.7
Long waiting time	13.2	19.2	14.8	11.8	22.8	17.1	11.5	15.6
No trained professionals	0.5	3.3	4.4	0.4	1.7	1.8	0.3	1.7
Too expensive	15.0	13.9	12.0	10.7	19.2	12.9	17.1	14.6
No drugs available	9.0	13.4	12.9	9.3	15.5	7.4	9.0	10.8
Treatment unsuccessful	3.9	8.6	9.8	5.9	4.7	4.9	4.4	5.8
Other	1.2	1.7	1.0	1.1	0.8	3.1	0.9	1.4
Faith-inspired								
None (satisfied)	89.5	91.3	80.6	100.0*	79.2*	89.4*	100.0*	90.0
Staff not welcoming	0.0	4.2	3.3	0.0*	0.0*	0.0*	0.0*	1.1
Long waiting time	3.2	0.0	0.0	0.0*	0.0*	10.6*	0.0*	2.4
No trained professionals	0.0	0.0	0.0	0.0*	0.0*	0.0*	0.0*	0.0
Too expensive	8.7	0.0	8.3	0.0*	20.8*	10.6*	0.0*	6.5
No drugs available	3.7	4.2	7.5	0.0*	20.8*	0.0*	0.0*	3.8
Treatment unsuccessful	0.0	0.0	0.0	0.0*	0.0*	0.0*	0.0*	0.0
Other	1.8	4.6	7.8	0.0*	0.0*	0.0*	0.0*	2.5
Private secular								
None (satisfied)	87.1	85.7	85.4	83.8	88.4	87.7	86.8	86.5
Staff not welcoming	1.7	1.6	0.5	3.7	0.8	0.3	2.9	1.7
Long waiting time	1.4	2.6	0.0	2.0	0.8	2.4	3.9	1.9
No trained professionals	0.0	0.4	0.0	0.0	0.0	0.7	0.0	0.2
Too expensive	6.9	6.9	9.1	3.8	6.9	7.5	6.8	6.9
No drugs available	2.8	2.8	3.5	5.2	3.3	1.6	1.3	2.8
Treatment unsuccessful	2.8	5.8	4.9	5.2	4.6	3.1	3.2	4.1
Other	0.6	0.7	0.9	1.8	0.0	0.4	0.3	0.6
All users								
None (satisfied)	78.4	75.5	78.3	77.1	74.6	77.1	78.5	77.2
Staff not welcoming	3.9	7.3	5.2	7.2	4.3	4.4	5.5	5.3
Long waiting time	7.0	9.9	6.4	6.4	11.6	9.2	7.2	8.2
No trained professionals	0.3	1.7	1.9	0.2	0.8	1.2	0.2	0.8
Too expensive	10.7	9.8	10.3	6.8	13.1	10.0	11.2	10.4
No drugs available	5.7	7.5	7.8	6.9	9.5	4.1	4.7	6.5
Treatment unsuccessful	3.2	6.9	6.7	5.3	4.6	3.8	3.7	4.7
Other	0.9	1.2	1.3	1.4	0.4	1.6	0.6	1.0

Source: Authors' estimations using household surveys.

Note: * indicates less than 20 observations – these cells are likely not to be reliable but provided for completeness.

Table 5: Satisfaction rates and reasons for non-Satisfaction in Mali (%)

	Residence Area		Welfare quintile					Total
	Urban	Rural	Q1	Q2	Q3	Q4	Q5	
Public								
None (satisfied)	67.7	60.8	55.1	63.5	60.4	65.9	67.3	63.7
Facilities were not clean	0.9	1.6	2.7	2.2	0.5	0.9	1.3	1.3
Long waiting time	17.8	7.7	14.9	9.5	8.1	10.5	16.5	11.9
No trained professionals	2.3	2.2	3.1	2.0	2.5	2.8	1.1	2.2
Too expensive	9.6	22.1	24.7	22.1	23.6	13.9	8.7	16.9
No drugs available	6.1	7.7	9.0	5.1	6.4	9.2	5.7	7.0
Treatment unsuccessful	5.2	9.2	14.4	8.9	9.6	5.5	4.6	7.5
Staff not welcoming	3.3	1.1	2.2	2.0	1.5	2.3	2.0	2.0
Other	0.4	2.2	0.2	1.3	3.2	2.2	0.0	1.4
Faith-inspired								
None (satisfied)	45.6*	85.0	53.6*	100.0*	100.0*	85.2*	0.0*	78.7
Facilities were not clean	0.0*	0.0	0.0*	0.0*	0.0*	0.0*	0.0*	0.0
Long waiting time	9.7*	0.0	0.0*	0.0*	0.0*	0.0*	55.8*	1.5
No trained professionals	0.0*	0.0	0.0*	0.0*	0.0*	0.0*	0.0*	0.0
Too expensive	37.1*	0.0	0.0*	0.0*	0.0*	14.8*	0.0*	6.0
No drugs available	0.0*	0.0	0.0*	0.0*	0.0*	0.0*	0.0*	0.0
Treatment unsuccessful	0.0*	15.0	46.4*	0.0*	0.0*	0.0*	0.0*	12.6
Staff not welcoming	7.6*	0.0	0.0*	0.0*	0.0*	0.0*	44.2*	1.2
Other	0.0*	0.0	0.0*	0.0*	0.0*	0.0*	0.0*	0.0
Private secular								
None (satisfied)	75.6	78.7	84.2	82.0	76.7	66.8	76.7	77.2
Facilities were not clean	0.4	0.5	0.6	0.3	1.2	0.0	0.4	0.5
Long waiting time	15.3	4.9	2.3	2.1	7.0	19.0	15.1	9.9
No trained professionals	0.1	2.0	2.3	0.7	2.1	1.0	0.0	1.1
Too expensive	3.0	5.6	3.3	6.4	5.5	6.1	2.2	4.3
No drugs available	0.3	4.2	3.2	4.8	3.8	1.4	0.2	2.3
Treatment unsuccessful	6.5	9.8	9.9	7.9	8.2	10.7	6.0	8.2
Staff not welcoming	0.7	0.5	0.8	0.0	1.3	1.3	0.0	0.6
Other	0.0	0.2	0.0	0.0	0.7	0.0	0.0	0.1
All users								
None (satisfied)	70.2	66.1	67.2	69.3	65.1	66.4	70.3	67.8
Facilities were not clean	0.7	1.3	1.7	1.6	0.7	0.7	1.0	1.1
Long waiting time	17.0	6.8	9.3	7.2	7.7	12.1	16.1	11.2
No trained professionals	1.5	2.1	2.7	1.6	2.3	2.4	0.7	1.8
Too expensive	7.5	17.3	15.2	17.2	18.6	12.3	6.6	13.1
No drugs available	4.2	6.6	6.4	5.0	5.6	7.4	3.9	5.6
Treatment unsuccessful	5.6	9.4	13.2	8.5	9.1	6.5	5.0	7.8
Staff not welcoming	2.4	0.9	1.6	1.4	1.4	2.1	1.4	1.6
Other	0.3	1.6	0.1	0.9	2.5	1.7	0.0	1.0

Source: Authors' estimations using household surveys.

Note: * indicates less than 20 observations – these cells are likely not to be reliable but provided for completeness.

After cost, the second main reason for non-satisfaction is long waiting time, again in virtually all countries. This was an issue for 11.5 percent of patients in Burundi, 11.2 percent in Mali, 10.5 percent in Senegal, 8.2 percent in the Republic of Congo, and 3.9 percent of patients in Ghana (in that country, the complaint ranks third after unsuccessful treatment). On this issue, FIIs do not seem to have a demonstrable comparative advantage versus public and private secular facilities. In some countries, complaints about long

waiting times are higher among faith-inspired facilities than among public facilities, but in other countries, the reverse is observed. As for the other reasons why some households declare being unsatisfied, sample sizes among faith-inspired facilities are often too small to be able to make a valid comparison with public facilities.

What could explain the better performance of faith-inspired providers in terms of the satisfaction-cost relationship as compared to public facilities? One explanation could be that faith-inspired providers provide services at a lower cost to households – possibly through efforts to make care affordable for the poor. This is what is observed in the next chapter in this volume on the basis of qualitative work for Burkina Faso by Gemignani and Wodon (2012). But when this is the case, it must be that faith-based providers have ways to reduce their own operating costs or have access to other resources in order to be financially sustainable, given that they often benefit from smaller support from the state than is the case for public facilities. Another potential explanation often mentioned in the literature could be that patients are more satisfied with faith-inspired providers despite higher out-of-pocket costs, as discussed by Olivier and Wodon (2012). The evidence provided in the next section tends to suggest that both factors may be at work, and that the answer depends on the specific countries (and probably facilities) being considered.

ESTIMATES OF OUT-OF-POCKET COSTS

This section provides cross-country evidence on the cost of healthcare using multi-purpose household surveys whose questionnaires include health modules with private cost data and distinguish between public, faith-inspired, and private secular providers. These are different surveys from those used in the previous section, so that it is difficult to compare the results between on actual out-of-pocket costs and the perceptions of costs discussed earlier. Still, the data provide valuable insights on out-of-pocket costs.

Average out-of-pocket costs for households of consultations are provided by type of provider in table 6 for nine countries where that information is available. These are not the total costs paid by households – for example transport costs are not included, but these are the costs paid to health facilities for the services received. The main interest is again in the comparison of the cost of public and faith-inspired facilities, but the table also provides data on other providers of healthcare.

The results are somewhat unexpected. In four countries (Burundi, Cameroon, Swaziland, and Zambia), consultation costs are similar between public and faith-inspired facilities, while one might have expected costs to be substantially higher in faith-inspired facilities because they tend to benefit only from limited support from the state. This is the case in three countries (Ghana, Malawi, and Nigeria) where public facilities are cheaper than faith-inspired facilities. But in Sierra Leone care provided in faith-inspired facilities tend to be substantially cheaper for households than publicly provided care. Thus, the comparison of out-of-pocket costs tends to be country specific, and in addition, differences in costs between public and faith-inspired providers tend to be smaller on average than one might have expected given the fact that state funding for faith-inspired providers is often limited so that they need to find other ways to achieve cost recovery.

It should be emphasized however that these broad comparisons of costs are provided across all types of facilities, and across all types of care seeking consultations, and this may affect comparisons. For example, in Ghana most faith-inspired providers are associated with the Christian Health Association of Ghana (CHAG), and the role of hospitals in CHAG is larger in relative terms than the role of hospitals in public facilities. The fact that hospitals tend to provide more intensive care that also tends to be more expensive could explain the differences in costs observed in table 6 whereby in that country, faith-inspired providers as a whole appear to be more costly than public providers. More detailed work could try to look at differences between providers according to the type of facility used by households (say, a clinic versus a hospital), but unfortunately, this is difficult to do in most countries because the sample size tends to be too small for such disaggregation (in many countries, the market share of faith-inspired providers is small, so that slicing the observations in the sample for those seeking care by type of facility tends to reduce the sample sizes too much for estimation).

Note that the same caveat applies for cost comparisons with other providers, especially because that group tends to be highly heterogeneous (it would include private secular facilities-based care as well as chemical stores and pharmacists, for example). Another issue that makes the comparison of out-of-pocket costs between providers difficult is the fact that insurances play a role – individuals who benefit from insurance and tend to be better off will typically use private secular providers more, but may have lower out-of-pocket costs because of their insurance coverage. This then may hide the true cost of care in household surveys. In the next section, a more detailed analysis of costs for Ghana will be provided with controls. But what is clear from table 6, is that as expected, faith-inspired tend to be at least as expensive as public providers, and this in turn is related to the fact that typically, faith-inspired providers receive only partial support from the state, so that they do need to request higher fees from households for cost recovery even when they benefit from a cost advantage if they can rely on dedicated staffs who may be willing to work for lower wages due to their desire to serve the poor.

Table 6: Cost of Healthcare Consultation, Local Currencies

	Residence Area		Welfare quintile					National
	Urban	Rural	Q1	Q2	Q3	Q4	Q5	
Burundi, 2006								
Public	861	230	175	160	114	118	593	244
Faith-inspired	653	192	63	41	499	58	366	208
Private secular	1558	337	137	120	351	439	879	455
Total	1164	243	155	137	203	170	622	277
Cameroon, 2007								
Public	1113	492	344	486	592	773	1151	729
Faith-inspired	937	658	531	678	687	852	963	774
Private secular	841	233	96	228	321	547	960	459
Total	979	410	266	397	494	702	1052	628
Ghana, 2005/06								
Public	9403	6866	4982	9567	7409	6292	9874	7902
Faith-inspired	11965	9176	4587	5469	13394	8290	14762	10343
Private secular	6600	2542	3210	1435	3510	4077	6574	4057
Total	8272	4824	4123	5207	5904	5327	8616	6175
Sierra Leone, 2003/04								
Public	6266	2603	1359	1907	2541	3386	6481	4058
Faith-inspired	3529	2183	1141	1184	2552	2175	4911	2597
Private secular	7873	2208	1820	906	2479	4363	8548	5368
Total	6824	2465	1447	1515	2520	3593	7207	4407
Swaziland, 2009/10 (total medical bill)								
Public	71	35	22	22	29	36	84	40
Faith-inspired	76	48	18	36	36	41	101	52
Private secular	765	270	43	448	146	822	349	419
Total	312	73	22	64	50	180	172	112
Zambia, 2004								
Public	5205	1841	1604	2121	2467	3347	4298	2937
Faith-inspired	7229	2667	2519	2082	2503	4292	4363	3244
Private secular	8214	3379	2602	3136	4771	3891	8893	5242
Total	6584	2459	2010	2513	3291	3620	6269	3847
Malawi, 2004								
Public	109	18	10	9	20	27	68	27
Faith-inspired	714	226	110	153	177	217	410	244
Private secular	154	26	11	17	22	44	74	36
Total	144	31	13	18	27	46	90	40
Nigeria 2003/04								
Public	529	506	185	191	284	401	937	516
Faith-inspired	1608	575	163	232	167	941	1478	997
Private secular	676	601	124	303	332	521	979	633
Total	621	553	156	244	303	464	973	582

Source: Authors' estimations using household surveys.

REDUCING COSTS FOR HOUSEHOLDS: A BRIEF CASE STUDY

It was mentioned in the previous section that Ghana is one of the countries in table 6 where out-of-pocket costs for faith-inspired providers tend to be higher than for public providers. In this section, more details are provided on Ghana's health system to suggest why this may have been the case at the time the household survey data used in table 6

were collected (in 2005-06 for that country), but also why this may be changing due to efforts in the national health policy to reduce out-of-pocket costs for households.

At independence, Ghana inherited a publicly funded health system that comprised mostly of government-owned health care service delivery. User fees were abolished making health care theoretically free. But facing economic contractions and shortfalls in funding for the health system, public health care facilities began charging user fees for services, as did faith-inspired facilities which in the absence of public subsidies could also rely on donations from foreign missions. While cost recovery was justified as a means to encourage greater accountability of health care providers while increasing facility-level autonomy over use of internally generated funds, user fees created barriers to accessing health care in the absence of appropriate risk pooling mechanisms in place. Concurrent with the formalization of user fees, a policy to exempt the poor accompanied the system, at least for public facilities. But these exemptions failed to reach their target groups.

Looking at health facilities in the Volta region, Nyongator and Kutzin (1999) found that exemptions were applied unevenly across health care facilities and income groups. They concluded that despite the policy to exempt 'paupers', the poor were either facing catastrophic health expenditures or were not seeking health care when needed. As a result, the poor continued to pay out-of-pocket for user fees at public (and faith-inspired) facilities. Out-of-pocket payments, the most regressive form of financing were the major source of funds for all facilities, whether public, faith-inspired, or private non-religious.

At the time of the last National Health Accounts in 2002, out-of-pocket payments accounted for about half of total health expenditures. Under these circumstances the evidence on whether faith-inspired facilities were able to subsidize services for the poor and be less costly than other facilities was mixed. For example, Asenso-Okyere (1995) suggested that *"since the quality of service is high, users are willing to pay for it. The poor who cannot pay the fees are exempted. Exemption can pose identification problems but since the missions operate mostly in the rural areas where people know each other it is usually not too difficult for a social worker to recognize the needy."* By contrast Nyongator and Kutzin (1999) suggested that facilities *"insist on the payment of deposits...for inpatient services, especially in mission hospitals. While it is fair to say that deposits help to promote cost recovery, they also pose a serious threat to accessibility."*

There have been however important changes in recent years in health service delivery in Ghana, so that what may have been observed in the past is not necessarily still relevant today. First, in comparison with other countries, CHAG has experienced an active collaborative relationship with the Ghanaian government. A Memorandum of Understanding was signed in 2003 between CHAG and the Ministry of Health, which has helped provide more state funding to CHAG facilities, especially for salaries. As of 2005 the government provided between 45 percent and 60 percent of CHAG's total operating revenues (CHAG 2006), and this may have increased further since. About 80 percent of this was for the salaries of about 7,000 CHAG health staffs. Thus in contrast to the time when CHAG facilities operated as mission organizations, they now obtain most of their revenues from government funding for salary costs and from the services they provide.

In addition, in an effort to remove user fees, provide protection against catastrophic health expenditures, and improve equity and access to care, Ghana created in 2003 the National Health Insurance Scheme (NHIS). The NHIS relies on a combination of earmarked tax revenues and income-based premium contributions to substitute for user fees. In this system, the funding follows the patient. Health care providers are reimbursed by the NHIS for services and drugs covered in the benefits package that are provided to NHIS members. The NHIS exempts vulnerable groups such as the indigent, the elderly, and children of enrolled members from paying premiums. The premium contribution levels are also income-based in order to reduce the burden on the poor. While the legislative instrument guiding the NHIS did set a narrow definition of the indigent category as a group with no identifiable source of income or shelter and fixed the percentage of enrolled members that qualify as indigent at 2.5 percent of those enrolled (versus a share of the population in poverty of 28.6 percent), the policy still has helped.

According to data from the NHIS website, as of June 2009 some 13.8 million individuals were registered in the scheme, representing close to 60 percent of the population. The program is managed by District Mutual Health Schemes, but in addition to members participating through district schemes, workers contributing to the Social Security and National Insurance Trust are also enrolled. On the provider side, public facilities are automatically accredited to participate, but in addition the NHIS has provisionally accredited 1,551 private healthcare facilities, including 400 hospitals and clinics, 237 maternity homes, 451 pharmacies, 329 licensed chemical shops and 128 diagnostic facilities (laboratories and diagnostic imaging facilities). Most of the CHAG facilities have been accredited. Makinen et al (2011) assess that CHAG currently has the highest share of NHIS-covered patients (73 percent), compared with public providers (69 percent) and self-financed private providers (56 percent). Overall, exempt groups, which do not have to pay to be part of the scheme, accounted for close to 70 percent of all registered members. By contrast, the estimations presented in table 6 were obtained with the GLSS5, which dates back to 2005-06, a time at which only a small share of the population has registered with the NHIS¹. Thus the situation has probably improved.

According to CHAG management, the NHIS has facilitated payments to CHAG member facilities for the services they provide and this is perceived by these facilities as a major improvement which may have further aligned the cost of care among FIIs and public facilities. Some issues may remain. For example, Ballou-Aares et al (2008) note that the rapid scale up of the NHIS has put a burden on claims processing. Administrators of CHAG facilities interviewed by Shojo et al (2012) cite delays in receiving funds, which affects their cash flow. As the Director of a CHAG hospital explained: *“the idea of the NHIS is perfect. It is good for the poor and brings clinics to a certain standard. But delivery has some problem. Our workload increased. It put stress on our finance because payment does not come regularly.”* Shojo et al (2012) also suggest that FIIs continue to

¹ Prior to the NHIS, some mission hospitals had actually instituted their own insurance schemes (e.g., the community insurance plan around St. Theresa’s Hospital in the Brong Ahafo Region) and this experience helped inform the introduction of the NHIS.

suffer from a lack of resources including medicines and technical equipment, with the situation more severe for facilities not yet accredited with the NHIS. Nevertheless, the need to rely heavily on out-of-pocket costs from patients to achieve cost recovery in faith-inspired facilities has greatly been reduced with the introduction of the NHIS and the memorandum of understanding signed between CHAG and the Ministry of Health, which shows how health reforms may work towards achieving more equity in financing.

CONCLUSION

Faith-inspired providers often aim to serve all – and many also have a commitment to serve the poor and vulnerable. However, the extent to which they are actually able to do so (given their resources) remains an open question. Even if FIIs do benefit from staff that are dedicated, some of whom may be able and willing to work for very low pay, running a health facility does cost money, and financial sustainability requires funding. When faith-inspired facilities do not benefit from state support, or when they benefit from lower levels of state support than public facilities, they often need to rely on cost recovery from patients and students to break even. When a higher level of cost recovery is required from users, it is more difficult for faith-inspired facilities to serve the poor, because the cost of their services becomes less affordable for those in need.

In this context, two questions were asked in this paper. First, is the cost of healthcare a major reason for not being satisfied with health services and does this differ between types of providers? Second, what is the out-of-pocket cost of healthcare for households? Overall, the results suggest that cost does remain a major concern for many households and that there are some differences in out-of-pocket costs between providers. Yet at the same time, these cost differences tend not to be as large as one might have assumed, and health sector reforms can help in reducing both these differences and out-of-pocket costs.

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