



# Faith-based healthcare in Africa: stylized facts from data collected by the Catholic Church

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## Introduction

As I read the articles included in this special issue, I was impressed by the richness and diversity of current research on faith-based healthcare in Africa. At the same time, I also felt that we still lack a good understanding of the “big picture”, including estimates of the size and characteristics of the faith-based health sector across countries, which matters for policy.

Just over a dozen years ago, as I was managing the Development Dialogue on Values and Ethics unit at the World Bank, I led studies on faith-based provision of basic services such as education and healthcare. Our small team including Jill Olivier, Clarence Tsimpo, Regina Gemignani, and Mari Sojo tried to answer a few basic questions: How large is faith-based provision of services? Does it reach the poor? How much does it cost for parents sending their children to school or patients using healthcare facilities? Were the services provided perceived to be of quality? And if parents or patients chose to go to faith-based facilities, why was this the case? For healthcare, the research suggested that the “market share” of faith-based facilities was smaller than often argued, especially when the different types of health providers that household rely on were accounted for. Faith-based services were found to reach the poor as much as public and private facilities. The out-of-pocket cost of faith-based healthcare was higher than for public facilities, but lower than for private facilities. Finally, patient satisfaction was higher for faith-based and private facilities than for public facilities. None of those results were surprising but having data (and a bit of

qualitative work) to back up these analyses made a small contribution to the field, even if the datasets had limitations.<sup>1,2</sup>

The analysis was based on household surveys for the most part, with limited other data available for triangulation. A decade later, however, as I started to do research on Catholic education as part of my volunteer work, I came across the annual statistical yearbooks of the Catholic Church. The yearbooks provide a wide range of statistics related to the Church, including estimates of the number of healthcare facilities it manages at the country, regional, and global levels. While data on the number of patients served at facilities are not available, trends in the number of facilities reveal interesting patterns. In this brief editorial, without comparing these data to other data sets as this would require more space, I would like to share a few stylized facts from the statistical yearbooks, hoping that they may be of interest to readers and provide context for the articles included in this issue of the journal.

## Data on Services Provided by the Catholic Church

Consider the statistical yearbook which provides data for 2020.<sup>3</sup> Data are available on the number of hospitals, dispensaries (I will instead use the term health centers), and leprosaria. Data are also available on facilities for the elderly and people with disabilities, although these will not be discussed here. Globally, the Catholic Church estimates that in 2020, it managed 5,245 hospitals, 14,963 health centers, and 532 leprosaria. These estimates

suggest that the Catholic Church remains today the largest faith-based provider of healthcare.

These estimates are from self-reported data from the chancery offices of ecclesiastical jurisdictions that fill an annual questionnaire, but they seem to be of sufficient quality to document broad trends over time. In a typical year, about five percent of the ecclesiastical jurisdictions do not fill the questionnaire, but this is the case mostly for small jurisdictions, so that missing data should not affect overall results substantially for most countries or global estimates.

How has the number of healthcare facilities operated by the Catholic Church evolved over the last four decades? In which parts of the world is growth observed, and where do we observe a plateau or a decline? How are the facilities distributed between hospitals, health centers, and leprosaria? And which are the countries with the largest number of Catholic healthcare facilities? In this editorial, I would like to share a few basic findings from a report I published two years ago.<sup>4</sup> More detailed data are available in the report as well as in technical papers based on these data.

## Number of Catholic Healthcare Facilities

Overall, there has been limited growth in the number of Catholic healthcare facilities over time, especially in comparison to the substantial growth observed for Catholic schools over the same period. While there was an increase in the number of health facilities managed by the Church from 19,119 in 1980 to 24,031 in 2010, this fell back to 20,740 facilities in 2020 due a decline in the last decade in the number of facilities in all regions except Africa and Oceania. From 1980 to 2020, the number of facilities increased by 2,550, which is also the increase in the number of facilities in Africa. Apart from Africa, there were also gains in Asia (628 additional facilities), and Oceania (396 additional facilities), but there was a decline in the Americas (loss of 844 facilities) and Europe (loss of 1,109 facilities).

In Africa, by 2020, the Catholic Church operated 6,926 healthcare facilities. Of those,

5,307 were health centers. This accounted for 35.5 percent of all health centers globally. Similarly, Africa accounted for 37.8 percent of all leprosaria. By contrast, the share of all hospitals located in Africa was smaller at 27.0 percent. The region with the second largest number of facilities was the Americas, followed by Asia and Europe, with Oceania being last. The fact that Africa and Asia are the regions with increases over the last few decades in Catholic healthcare facilities is not surprising, given that these two continents have higher rates of population growth (and thereby increasing needs) and that thanks to efforts to achieve universal health coverage, many public and private networks of healthcare facilities have expanded.

Also noteworthy is the fact that the number of Catholic hospitals has been declining for some time globally (perhaps in part because of consolidation or take-over by private secular hospital chains in high-income countries), while the decline in the number of health centers is more recent. As to leprosaria, their number has been declining and we would expect further declines in the future given the fact that the illness is much less prevalent today than it was in the past.

## Differences between Regions and Countries

There are differences between regions in the share of facilities by type. Globally, hospitals account for 25.3 percent of all Catholic healthcare facilities in 2020, versus 72.1 percent for health centers, and only 2.6 percent for leprosaria. In Africa, hospitals account for 20.5 percent of all facilities, while health centers account for 76.6 percent of all facilities. By contrast, in Oceania and Europe, hospitals account for almost a third of all facilities. As for leprosaria, they matter most in South Asia (6.4 percent of all facilities) and Africa (2.9 percent). As already mentioned, globally, there has been a progressive decline in the share of hospitals and leprosaria, while the share of health centers has increased in all regions except Europe. However, in terms of both the absolute number of facilities and the shares of facilities by type, the period from 2010 to 2020



shows the number of health centers managed by the Catholic Church falling substantially in all regions except Africa.

Another finding is that there is a lot of heterogeneity between countries in the number of facilities, as one might expect. Together, the 15 countries with the largest number of Catholic healthcare facilities in 2020 account for more than half of all healthcare facilities managed by the Church globally. India, a lower-middle income country according to the World Bank classification, and the Democratic Republic of Congo (DRC), a low-income country, reach the top two positions in terms of the number of Catholic healthcare facilities, as is the case for Catholic schools. In India, this is because of the sheer size of the country. In the DRC, it relates to the strong presence of the Church in a historical context marked by conflicts, and funding provided by the state, as is the case for Catholic schools. Next is Germany, which is not among the top countries for the number of Catholic schools but has many health centers. Mexico, Brazil, and the United States follow, with many hospitals in the United States. The other countries are all lower-middle income countries according to classification of the World Bank.

### Presence in Low-income Countries

Overall, in comparison to primary and secondary Catholic schools, the footprint of Catholic healthcare facilities is less tilted towards low-income countries. Nevertheless, six in the top ten countries in terms of the number of Catholic healthcare facilities are low or lower-middle income countries, an encouraging observation for the mission of the Church to serve the poor. Yet there is a risk for Catholic healthcare facilities to serve proportionately more the well-to-do than the poor. Even if many Catholic healthcare facilities are in countries with comparatively low levels of income, facilities may not be located today primarily in poor areas, even if this may have been the case in the past.<sup>5</sup> The risk of serving the well-to-do proportionately more than the poor has long been recognized, as Catholic healthcare facilities face many of the same issues that affect

other Catholic services in terms of their staffing and sustainability. Congregations which used to be able to provide quasi-free healthcare a few decades ago may not anymore have the personnel and resources to do so today. In countries where Catholic health facilities do not benefit from state support, cost recovery may lead the facilities to be less affordable for some among the poor. In healthcare as compared to education, state funding for Catholic facilities is more common, as the experience of some Christian Health Associations suggests<sup>6</sup>, yet competitive pressures may become more severe over time.

### Reasons for Choosing Catholic and other Faith-based Facilities

Although this does not emerge directly from data on the number of facilities managed by the Catholic Church, there is a fundamental difference between education and healthcare in the reasons for choosing Catholic and other faith-inspired providers. In the case of education, the emphasis on the transmission of values and the faith through schools is often a reason for parents to enroll their children in a Catholic or other faith-based school. In the case of healthcare, faith and values may play a positive role in the care being provided but are not the key factors leading patients to choose a Catholic or other faith-based hospital; it appears instead that the quality of the services provided is a more important factor.<sup>7</sup>

### Conclusion

The articles provided in this special issue adopt a wide array of approaches and methods to discuss aspects of faith-based healthcare provision in Africa. However, we still need to better answer some of the basic questions about the faith-based health sector, such as its “market share”, reach to the poor, perceived quality, cost for patients, and other characteristics. These questions are essential especially for the dialogue with policymakers, and the ability of the faith-based sector to benefit from state support. Some of the papers in this issue of the journal deal at least in part with these issues, but not typically in a comparative perspective. The

richness of research in the field is growing but we still have quite a bit of work to do to inform public policy towards faith-based healthcare and to better integrate faith-based facilities in national networks of providers. I hope that this could be the topic of future essays in this journal.

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