



# **Access to Financing: A Constraint to Private Health-Sector Development**

Meaghan Smith, MIA



**COMMERCIAL MARKET STRATEGIES**  
NEW DIRECTIONS IN REPRODUCTIVE HEALTH

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**KEY WORDS**

Financing, Loans, Private Health Sector, Small and Medium Enterprise Development

# Table of Contents

<b>Executive Summary .....</b>	<b>1</b>
Is Access to Finance a Constraint to Private Health-Sector Development? .....	2
How Does Lack of Financing Constrain the Private Health Sector?.....	2
<b>The SME Development Framework .....</b>	<b>3</b>
Definitions .....	3
Why Use an SME Development Framework to Analyze the Private Health Sector? .....	5
Constraints to the Development of Small and Medium Enterprises.....	5
<b>Access to Finance and the Private Health Sector.....</b>	<b>9</b>
Review of Current Literature.....	9
Summary of the Summa Foundation’s Findings on Access to Finance .....	14
<b>Summary of Findings .....</b>	<b>18</b>
<b>Conclusion.....</b>	<b>20</b>
<b>References.....</b>	<b>21</b>

# Executive Summary

The private health sector has a critical role to play in contributing to public health outcomes in developing countries. While acknowledging this role, donors and governments grapple with a number of key issues in partnering with the private sector. These issues include how to improve quality; how to integrate critical public health services, such as family planning; and how to achieve significant scale. Over time, a number of strategies have been developed to tackle these issues and improve partnerships with the private sector. Lack of finance has been identified by both providers and public health practitioners as a major constraint to the development of the private health sector and its ability to contribute to positive public health outcomes.

Expanding access to finance is increasingly recognized as a useful tool in working with the private sector. In a climate of limited resources, however, it is important for public health policymakers to assess the magnitude of the financing constraint and to determine the effectiveness of increasing access to finance in improving public health outcomes through the private sector. This paper seeks to inform the policy debate by answering the following questions:

- Is access to finance a constraint to the development of the private health sector?
- If the answer is yes, how does lack of finance constrain private-sector development?

This paper will take an innovative approach by using a small and medium enterprise (SME) development framework to answer these questions. Private health providers face many of the same constraints and opportunities as other types of commercial enterprises. Most health providers in developing countries can be classified as micro, small, or medium enterprises.<sup>1</sup> The SME development field has been working with commercial enterprises for decades in order to promote development outcomes, and offers a variety of methodologies, tools, and lessons learned that can be adapted by public health professionals to complement existing programs. Specifically, the SME development field has designed and tested strategies for overcoming the three major constraints to the growth of small businesses, which include the enabling environment, the capacity of the SME, and access to financing.<sup>2</sup> Accordingly, the SME development field offers public health policymakers a new perspective for analyzing the access-to-finance constraint and strategies for overcoming it.

Since this paper was written for public health practitioners who may have a limited knowledge of the SME development field, it begins with a brief introduction to SME development and SME access-to-finance issues in order to establish a framework for analyzing the private health sector.<sup>3</sup> The paper then shifts gears and employs a literature review as well as Summa Foundation<sup>4</sup> assessments in Uganda and the Dominican Republic to examine whether and how lack of

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<sup>1</sup> This paper will focus on small and medium health providers, while recognizing that micro health enterprises are an important part of the private sector and face many of the same constraints.

<sup>2</sup> The SME Finance Toolkit developed by USAID's Office of Economic Growth, Bureau for Economic Growth, Agriculture and Trade, [www.usaid.gov/economic\\_growth/egat/eg/tech-financial/sme\\_toolkit/index.htm](http://www.usaid.gov/economic_growth/egat/eg/tech-financial/sme_toolkit/index.htm), is an example of the resources that are available.

<sup>3</sup> This paper is not intended to provide an in-depth review of SME finance. Readers who are interested in this subject should refer to the reference section for additional resources.

<sup>4</sup> The Summa Foundation is a not-for-profit investment fund that was created by USAID to provide financing and technical assistance to the private health sector. Summa also has a mandate to research and disseminate innovative strategies for working with the private health sector.

financing constrains private health providers. This is followed by a summary of findings, the most important of which answer the questions posed by this paper.

### **Is Access to Finance a Constraint to Private Health-Sector Development?**

The literature review revealed that like other types of SMEs, private health providers consider access to financing to be a major constraint to growth. Furthermore, the Summa Foundation's assessments of the banking sectors in Uganda and the Dominican Republic indicate that commercial lending to health providers in these countries is minimal, and that many commercial banks are reluctant to lend to the private health sector.

### **How Does Lack of Financing Constrain the Private Health Sector?**

This analysis revealed that lack of financing can have a number of serious consequences for the development of the private health sector. For example, it can have a negative impact on both quality and scale — resulting in a private sector dominated by small clinics with limited capacity. The link between small, organizationally simple health facilities, such as single-practitioner clinics, and reliance on self-financing is a theme that runs throughout most of the literature. When access to credit is a problem, small private providers have a limited ability to scale-up into more organizationally complex forms, such as group practices, franchises, or networks. This finding has significant policy implications for donors and governments interested in working with the private health sector to achieve scale. Furthermore, a survey of private providers in Tanzania suggested that self-financing due to credit constraints resulted in small practices that did not meet the Ministry of Health's quality standards (Munishi et al., 1995). And an important World Bank study found that where there are many obstacles to growth, firms tend to enter the informal sector as a survival strategy (Ayyagari et al., 2003). This finding has serious implications for the private health sector because in most developing countries, the informal health sector is characterized by quality issues, a lack of regulation, and small outlets with limited capacity.

# The SME Development Framework

This paper takes an innovative approach to analyzing the private health sector by using a small and medium enterprise development framework — recognizing that private health providers face many of the same opportunities and constraints as other types of commercial enterprises. The approach taps the SME development field for a variety of methodologies, tools, and lessons learned, garnered over decades of working with commercial enterprises to achieve development objectives.

Since this paper has been primarily written for public health practitioners who may have a limited knowledge of SME development, this section provides a brief overview of the field in order to place the discussion in an SME framework. The overview begins with key definitions, such as small and medium enterprises, small and medium enterprise development, and the private health sector. It then outlines the rationale for using an SME development framework for analyzing the private health sector. Finally, it concludes with a discussion of the three major constraints to SME development, with the main focus on access to finance. Readers interested in a more detailed discussion of SME development and SME finance should refer to the reference section for additional resources.

## Definitions

### Small and Medium Enterprises

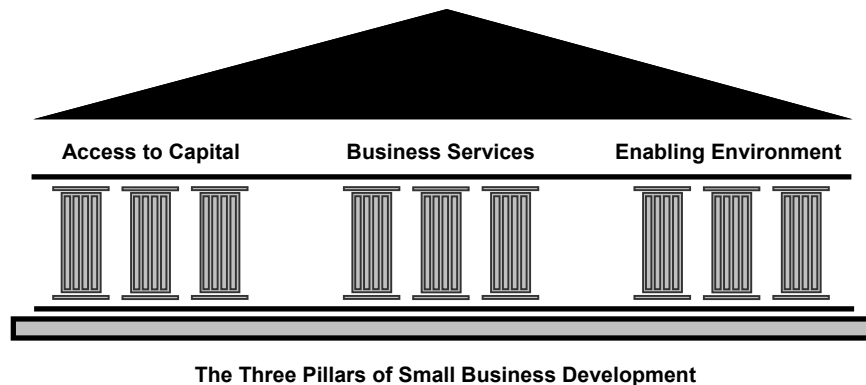
Small and medium enterprises play a critical role in most developing economies. SMEs stimulate private ownership and entrepreneurial skills; are flexible and adapt quickly to changes in market demand and supply; generate employment; and contribute to the growth of the economy (Schmognerova, 2002). Unfortunately, there is no uniform definition of small and medium enterprises; the meaning of the term varies by country and donor, with differing criteria, such as number of employees, total net assets, and sales. This paper will categorize firms based on number of employees, the most common criterion. Using USAID's definition, microenterprises are firms with 10 or fewer employees, and SMEs are firms with 11 to 300 employees. Small firms are defined as having 11 to 50 employees, and medium firms, 51 to 300 employees (USAID, 1995). While these definitions provide a general framework for the reader, in reality firm size can be fluid and relative, and must be adjusted to account for regional differences in economic development and for variations in the private sector.

### Small and Medium Enterprise Development

Most donors support SME development as a strategy to increase employment opportunities, drive economic growth, and alleviate poverty. Despite the importance of SMEs to development, the majority face a number of impediments. Most SME development projects therefore seek to remove these impediments and stimulate the growth of the sector. Typical SME development strategies include the following components:

- Improve access to finance
- Strengthen SME capacity
- Improve the enabling environment for SMEs

The International Finance Corporation, the private-sector investment arm of the World Bank Group, describes these strategies as the three pillars of small business development, as illustrated here.<sup>5</sup> Each will be discussed in more detail below, with a focus on access to finance.



### **The Private Health Sector**

The private health sector consists of a number of different actors, including health product manufacturers, health product distributors, insurance companies, and private health providers. While most of the literature reviewed for this paper focuses on private health providers, the majority of the findings are also applicable to other types of private health-sector businesses. The term “private health provider” is broad and covers both formal- and informal-sector businesses of varying sizes. Larger providers include hospitals, group practices, networks of clinics, franchises, and some pharmacies. Smaller providers include individual practitioners, such as midwives, nurses, and doctors. The informal sector is comprised mainly of traditional birth attendants, unlicensed health practitioners, and unlicensed drug shops.

Using an SME development framework, providers with fewer than 10 employees (such as individual practitioners and informal-sector providers), are classified as micro-enterprises. Few health enterprises in developing countries have obtained the scale necessary to be considered large enterprises; the few that have include larger health product manufacturers (such as Cipla in India); hospital groups (such as San Pablo Hospital Group in Peru); and multinational health care companies. Much more common in most developing countries is a private health sector dominated by micro, small or medium enterprises, including private practitioners, hospitals, franchises, and networks of clinics. Of the 13 loans that the Summa Foundation disbursed under the USAID-funded Commercial Market Strategies Project, only one was to a large business — Peru’s San Pablo Hospital Complex, which has 660 employees. The remaining 12 loans went to businesses with fewer than 50 employees.

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<sup>5</sup> IFC, 2003



This paper will examine how access to finance contributes to the size distribution of health care businesses in a developing country. While the focus of the paper is on small and medium health enterprises, it should be noted that micro health enterprises also play an important role in developing countries and face similar constraints, including access to finance.

## **Why Use an SME Development Framework to Analyze the Private Health Sector?**

Donors are increasingly interested in working with the private health sector for a variety of reasons: The private sector can be an efficient provider of services. It can fill the gap created by limited donor and government resources. And in many countries, consumers are increasingly seeking care from the private sector. In working with the private sector, however, donors are grappling with a number of key issues, including how to improve quality; how to integrate critical public health services, such as family planning; and how to achieve significant scale. In the past, a number of strategies were devised to address these issues, including accreditation programs, clinical training, and subsidies. Most of these strategies were designed by public health professionals with public health objectives in mind. In recent years, though, donors have shown an increased interest in using a more business-oriented approach to working with the private sector. New models, such as networks and franchises, have been developed to increase scale and improve quality.

This more business-oriented trend has the potential to yield significant gains in working with the private health sector — approaching the private health sector from a purely public health perspective has provided only half the picture. Private health providers are also businesses facing many of the same constraints and opportunities as other types of commercial enterprises. Business approaches and models, however, should not be adopted arbitrarily or in a piecemeal fashion, but in the context of a broader framework. With such a considered approach, the SME perspective offers donors and governments a new framework for working with the private sector; one that complements more traditional public health programming. This paper supports this new process by analyzing access to finance and its impact on the private sector, using the SME development framework.

## **Constraints to the Development of Small and Medium Enterprises**

Having established the rationale for using an SME development framework in working with the private health sector, this paper first considers constraints to the development of SMEs in general and then focuses on the private health sector. Using a cross-country SME database, the World Bank has found that “in countries where there are many obstacles to firm growth, and particularly to SMEs, firms tend to migrate to the informal sector to overcome these obstacles (Ayyagari et al., 2003).” This finding has significant implications not only for general SME development, but also for strategies to promote the private health sector and to achieve scale. (This World Bank finding is supported by data in the literature review on access to financing for private health providers, and will be discussed in more detail below.) The major factors that constrain the growth of a business are typically categorized as the business environment, SME capacity, and access to financing. Although each of these factors is inter-related, this paper will first briefly examine the environment and capacity. The access-to-finance discussion, as the main subject of this paper, is then treated in more detail.

## **The Business Environment**

In the developing world, the business environment can be particularly important in determining whether a business grows, remains static, or fails. Factors that shape the business environment include red tape (such as excessive demands for licenses, permits, inspections, and fees); inadequate contract enforcement; the legal, regulatory, and policy frameworks; a repressive tax regime; limited property rights; and corruption (Brown et al., 2002). Thus a business environment that negatively affects a health care provider might include high registration fees and excessive import duties on medical equipment, commodities, and drugs. A World Bank study of enterprises operating in 54 countries found that in countries with legal and regulatory problems, small and medium enterprises have slower growth in comparison to larger firms (Beck, 2002). Larger firms either have a better capacity to get around legal inefficiencies or are able to use them to their advantage.

## **SME Capacity**

One of the major barriers to SME growth is internal. Many small entrepreneurs lack the business and management skills that are necessary to significantly scale-up a business. A frequent complaint from small business owners is that the environment and lack of financing are curtailing growth. In reality, however, many owners lack the skills that are necessary to make optimal use of the capital that they have and to negotiate the existing business environment. These skills include general management, organizational development, marketing, financial management, human resources, and quality and cost control (Morris et al., 2001). Banks frequently complain that SMEs are “informationally opaque,” and they are reluctant to lend due to poor-quality financial statements and business plans. Internal capacity is also a major issue for health providers, who typically are clinicians, not business people.

## **Access to Finance**

While the business environment and capacity of SMEs are important constraints, the focus of this paper is to explore the third factor: access to finance. The paper will analyze whether and how access to finance impacts the development of SMEs in general and then more specifically, private health providers.

Surveys conducted throughout the world have found that small business owners cite access to finance as either the largest constraint to growth, or one of the largest. The literature review done for this paper demonstrates that private health providers are no different in this assessment. Access to finance is, however, a broad term — as is demonstrated by the range of specific factors that small business owners cite when asked about the financing barriers they face. These factors include

- Collateral requirements of banks and financial institutions
- Bank paperwork and bureaucracy
- High interest rates
- Need for special connections with banks and financial institutions
- Banks lack money to lend

- Limited access to foreign banks
- Constricted access to non-bank equity
- Limited access to financing to lease equipment
- Constricted access to long-term loans<sup>6</sup>

But examining this issue from the business owner's perspective captures only part of the story. When banks and financial institutions are asked why they limit lending to SMEs, they have their own set of explanations. Frequently-cited barriers to financing from the bank's perspective include

- Inadequate information on potential borrowers (no credit bureaus)
- Poor business plans and financial statements
- Weak property laws
- Transaction expense of lending to an SME (more time consuming)
- Bank officers' limited understanding of SMEs and SME lending<sup>7</sup>

There is significant research that documents that access to finance is a major constraint to the growth of SMEs in the developing world. A few key pieces of the literature are highlighted below. A study funded by USAID showed that SMEs in Bulgaria do not have adequate access to commercial lending or to long-term credit (Morris et al., 2001). Furthermore, when loans were available, collateral requirements were high (1.25 to 3 times the value of the loan) and terms were short (1 to 2 years). The Bulgaria study also identified a financing gap in the \$100,000 to \$300,000 range, a typical SME financing range. In addition, a USAID-funded study in Romania found that 78 percent of SME owners interviewed identified access to capital as a "very constraining" factor; the percentage was higher among smaller and slower-growing firms (Brown et al., 2002).

It is one thing, however, for small business owners to report their perception that financing is a constraint. A more important question is whether lack of financing actually does constrain growth — and if so, what the contributing factors are. A World Bank study examining the constraints facing a size-stratified sample of over 4,000 firms in 54 countries looked at this more detailed question. The study found that SME growth is affected by a lack of financing (Beck, 2002). Specifically the study found that "medium-size firms, and particularly small firms, are significantly and negatively affected by collateral requirements, bank paperwork and bureaucracy, high interest rates, the need to have special connections with banks, banks' lack of money to lend, and access to financing for leasing equipment." This study provides evidence that financial constraints have a more significant impact on the operation and growth of small and medium firms than on large firms. The International Finance Corporation concluded that as a result of these financing constraints, SMEs are dependent on their own cash flow or other less reliable sources of capital, such as loans from friends and informal moneylenders (IFC, 2001).

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<sup>6</sup> Source: Beck T., et al., World Bank 2002

<sup>7</sup> Sources: Brown D., et al., 2002 and IFC, 2001

With such limited financing, SMEs have difficulty growing and scaling-up, which handicaps their ability to contribute to the growth of their country's economy. Looked at from this broader perspective, increasing financing options for SMEs can be seen as a policy imperative for donors and governments (IFC, 2001).

# Access to Finance and the Private Health Sector

In laying out an SME development framework, this paper has documented that small and medium enterprises in developing countries face a number of constraints, among them access to finance. It has also noted that many health care providers in developing countries — including the majority of hospitals, clinic networks, franchises, and larger clinics — are small and medium enterprises. Accordingly, the SME development framework is a valid tool for analyzing constraints to the private health sector and for identifying potential strategies to overcome these constraints.

This paper now examines whether access to finance is a constraint to private health providers, as it is to other types of SMEs, and if so, how. This analysis is based on a review of the current literature on the subject, and on the findings of Summa Foundation assessments in Uganda and the Dominican Republic.

## Review of Current Literature

Unfortunately, there is markedly less documentation on access to finance for private health providers than for SMEs in general. Furthermore, most of the private health provider literature is less detailed and not as recent — often dating from the mid-1990s. In addition, it frequently appears as part a broader discussion of constraints to the private health sector as a whole. And the relevant research typically does not probe the detailed factors that make access to finance an issue. Instead, it is primarily based on surveys of private providers, conducted by researchers who are not financial specialists, that ask providers themselves if credit is a constraint. Finally, despite anecdotal evidence that access to finance is a problem in most of the developing world, the majority of the literature that was identified is based in Africa.<sup>8</sup> Despite these limitations, however, important trends emerge from the literature review — trends worth understanding and analyzing.

The literature review comprises more than 30 published and unpublished documents, including annual reports, research studies, conference proceedings, and trip reports. This paper highlights nine of the most relevant documents, beginning with those that employ a global perspective and followed by those with a country-specific focus.

Considered as a whole, the reviewed documents reveal that access to financing is a major constraint to private health-sector growth. Furthermore, the documents indicate that lack of financing can have a negative impact on both scale and quality: A consistent theme is that when financing is a constraint, the private sector is dominated by small clinics with limited capacity. Furthermore, when access to credit is a problem and clinics are forced to rely on self-financing, quality issues often arise. These findings have significant policy implications for donors and governments interested in working with the private health sector to achieve scale and improve quality.

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<sup>8</sup> In discussions with private providers, the Summa Foundation has identified access to finance as a constraint in all regions.

### ***The International Finance Corporation's 1998 Annual Report***

In its 1998 Annual Report, the International Finance Corporation identified the private health care industry as a “frontier sector” — defined as a sector within a country where there is very limited capital availability. Guy Ellena, head of the IFC’s Health and Education Department, explains that the health sector qualifies for frontier status because most commercial banks in the developing world are wary of lending to it. The report states that the IFC’s health-sector strategy is to demonstrate the viability of health-sector investments, with the expectation that commercial banks will follow its lead, much as they have done in other industries (IFC, 1998).

### ***Factors Affecting the Development of Private Health Care Provision in Developing Countries***

In this 1993 review of factors affecting the development of private health care provision in developing countries, Peter Berman and Ravindra Rannan-Eliya found that capital is an increasingly important health care input. They suggest that the supply and cost of capital may be a more important factor in determining the level of private health care provision in developing countries than in developed countries (where it is relatively easy to obtain). Their paper further suggests that the more complex the health care organization — for example, a hospital, franchise, or network — the more dependent it is on capital to grow. Private practices owned by a single provider are typically self-financed through business cash flow or capital provided by friends or family. While banks can act as a source of financing, the amounts tend to be limited. Expansion beyond the scale of a single clinic requires access to additional capital, which is often restricted by the formal banking sector (Berman and Rannan-Eliya, 1993).

### ***Summary of Country Case Studies: Private Providers' Contributions to Public Health in Four African Countries***

This 1994 paper by Hursh-Cesar and others presents general conclusions from a series of four research papers written as part of the USAID-funded Data for Decision Making Project and the Health Financing and Sustainability Project. These papers examined the private health sector in Kenya, Tanzania, Senegal, and Zambia; their findings were presented at a 1994 Nairobi conference (“Private and Non-Government Providers: Partners for Public Health in Africa”). Each study examined both supply and demand factors affecting private health services, using an extensive literature review as well as a field survey of private providers in small sample sites.

The studies revealed that the most constraining service supply factors are lack of access to capital and high government taxes on imported drugs, medical supplies, and equipment. During the period of review, the studies found that in all four countries there was a contraction of bank credit and an increase in interest rates. Furthermore, there were no specialized financial institutions that lent to health providers. As a result, the authors found that private-sector growth was dominated by small clinics. The studies determined that lending to the health sector is not attractive to banks and other financial institutions because of the lack of collateral. Medical equipment and facilities can be highly specialized and difficult to sell, resulting in a low liquidation value if a loan is defaulted. Accordingly, in each of the four countries private providers are constrained by the difficulty in accessing capital that is necessary to fund practice start-up and day-to-day operations and to maintain drug stock (Hursh-Cesar et al., 1994).

### ***Kenya: Non-Governmental Health Care Provision***

The Kenya country study was prepared for the USAID-funded Data for Decision Making Project in collaboration with the African Medical Research Foundation by Berman and others. The study included a literature review of 45 documents and a field survey of 194 private providers in four sites. (Providers included 107 modern providers, 52 pharmacists/chemists, and 35 traditional healers.) The study found that the health sector requires significant capital inputs, including initial capital outlays for start-up and working capital for day-to-day health facility operation. Typical expenditures include paying several years of rent in advance (a requirement of many landlords); malpractice insurance; and keeping adequate drug stocks, as specified in regulations set by the Medical Practitioners and Dentists Act. These large capital requirements are a constraint to many health providers who are considering establishing a private practice.

The authors found that while Kenya's capital market was fairly developed, access to credit was an issue for private health providers. Typically, health providers do not have enough collateral to secure loans and, due to the specificity of medical facilities, liquidation value of collateral can be low. These factors make lending to the health sector unattractive. Exacerbating this situation, the study found that banks were limiting lending due to a number of macroeconomic factors. As a result, the study found that most health providers were either self-financed or used other financing mechanisms, such as supplier credit. These conclusions are corroborated by an earlier study (Kibua, 1992) that found that most private providers in Kenya used personal savings to finance the start-up of their practices. In addition, the Berman study found that hospitals are more likely to receive bank loans than clinics, and that there are no specialized financial institutions within Kenya that lend to the health sector (Berman et al., 1995).

### ***Private-Sector Delivery of Health Care in Tanzania***

The Tanzania country study was prepared as part of the USAID-funded Health Financing and Sustainability Project by Munishi and others in 1995. The study relied on secondary sources of information as well as on field interviews with a random-sample survey of 61 private providers and interviews with patients in Dar-es-Salaam and Kilimanjaro. (The survey did not cover the informal sector.) The survey revealed that lack of capital is a major constraint to the growth of the private health sector in Tanzania. Ninety-three percent of for-profit providers and 83 percent of not-for-profit providers cited the availability of capital as a difficulty in the start-up of operations. Please refer to Table 1.

*Table 1: Ease of access to capital at start-up as a percent of respondents<sup>9</sup>*

Availability of Capital	For-Profit		Not-for-Profit	
	Easy	Difficult	Easy	Difficult
	7%	93%	17%	83%

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<sup>9</sup> Source: Munishi et al., 1995

Here, too, credit constraints were cited as having implications for both scale and quality. For example, private providers consistently complained that credit to finance buildings, equipment, and drug supplies was difficult to obtain. According to the study, Tanzanian financial institutions do not consider the health sector a viable area for investment, citing collateral concerns as a major factor. The study found that providers therefore largely limit themselves to establishing small dispensaries and pharmaceutical outlets, rather than hospitals and specialist clinics, which require larger capital investments. This finding has serious implications for the private sector's ability to achieve scale. The survey found that the majority of providers who are seeking to establish a private practice are low-paid practitioners who have either retired with a nominal pension or are still employed in the public sector. These practitioners have limited savings for investment in a health facility, and typically have no collateral to secure a loan. As a result of these capital constraints, the study found that recently established one-person facilities (microenterprises) were largely self-financed and often established in one or two rooms of a residence — and fail to meet Ministry of Health standards.

The Tanzania country study raised the issue of the impact of the credit constraint on the quality of services provided by the private health sector. The study suggested that some form of loan guarantee could be used to help the private sector expand capacity and improve quality (Munishi et al., 1995).

#### ***Senegal: Private Providers and Public Health***

The Senegal country study was prepared by Knowles and others for the USAID-funded Health Financing and Sustainability Project. The study conducted a literature review of 20 sources; visited 70 facilities in Dakar and rural areas; and interviewed 60 owners/managers of a wide range of private health facilities. Nearly half of roughly 60 respondents complained about problems in obtaining start-up financing. When they were able to obtain financing, respondents complained of high interest rates. The study recommended streamlining credit procedures and suggested that better access to credit might induce some providers to relocate to under-served areas outside of Dakar (Knowles et al., 1994).

#### ***Zambia: Private Providers and Public Health***

The Zambia country study was produced as a working paper for the USAID-funded Data for Decision Making Project by Berman and others, and included a literature review of just over 80 documents, as well as a small survey of 43 facilities. The study found that the greatest constraints to the growth of private health services in Zambia are lack of skilled human resources and limited access to capital and credit. It further noted that financing for facilities, equipment, and operating costs can be critical in the expansion of the private sector. The study found that as a result of the macroeconomic environment in Zambia, there was more demand for credit than supply. A private-sector representative to the Zambia National Conference on Public/Private Sector Partnership for Health — Dr. Munkonge, owner of the Hilltop Hospital in Lusaka — emphasized this point by stating that lack of access to credit remained a major constraint for private-sector health care facilities.

The Zambia study reviewed the country's Medical Council records and found that clinics established during the early to mid-1980s were mainly industrial clinics attached to large companies. This suggests that access to credit was a problem for other types of providers, since large formal-sector employers have an advantage in obtaining credit to establish a clinic. If the



availability of credit led to the growth of employer-based clinics and limited the development of other types of private providers, informal-sector workers, the unemployed, or those who do not otherwise have access to employer clinics would have limited access to the private sector in comparison to those employed in the formal sector. The study also suggested that capital may be more important for more organizationally complex providers, and that lack of credit can impact the potential for scaling-up (Berman et al., 1994).

### ***Private Health Care Provision in the Greater Accra Region of Ghana***

In addition to the four country studies, a more recent research project in Ghana highlighted many of the same issues. This 1999 study was prepared for the Partnerships for Health Reform Project by Obuobi and others. This study was based on a survey of 69 private physicians. The major business limitation cited by these providers was lack of access to credit and capital, followed by infrastructure constraints and an unfavorable tax environment. Although randomly selected, 86 percent of the physicians surveyed were 45 years and older. The researchers conducted follow-up interviews to identify the factors contributing to this older age structure. Two main factors cited as barriers to private-sector entry of younger physicians were:

- High start-up and on-going costs
- High interest rates and the inability of many doctors to secure bank loans due to a lack of collateral

These responses suggest that lack of access to credit and reliance on self-financing delays start-up. The survey also found that the majority of for-profit providers (61 percent) were in small private practices as opposed to larger group practices. These small private practices typically consisted of outpatient facilities that supported one physician. This finding is similar to other studies suggesting that when access to credit is a problem, private providers tend to be small, and that their ability to scale-up into more organizationally complex forms — such as group practices, franchises, or networks — is limited. The study recommends that mechanisms should be developed to provide financing to providers so they can acquire modern facilities and better serve their clients (Obuobi et al., 1999).

### ***Strengthening Health Services in Developing Countries Through the Private Sector***

The literature review concludes with relevant findings from this Charles Griffin paper, which provides a slightly different perspective on the access-to-financing discussion. In exploring whether the public sector or the private sector makes better use of investment resources, Griffin reviewed a Philippine study comparing performance indicators for the public and private health sectors from 1972 to 1983. The study suggests that growth in the supply of health services between 1972 and 1983 was led by the private sector, and that the private sector was more successful in targeting investment to provinces with the greatest need — that is, to lower-income and underserved areas.

According to Griffin, the private-sector results appear to have been partially driven by a Development Bank of the Philippines loan program that supported private hospitals. Griffin concludes that a program for investing in private-sector hospitals can have positive development outcomes. He states, “the litmus test for governments or donors in deciding whether to support loans for private hospitals is whether the state is able and willing to provide the same services that

would otherwise be provided privately and can do so at a lower cost. If they cannot, and private providers are willing to take the risk, only on ideological grounds could the project be opposed.” Griffin argues that promoting private provision may be a more efficient use of resources than for the government to provide services directly. Instead it may be more efficient for the government to use its regulatory function to support public health outcomes in the private sector. For example, the government can attach conditions to the private health facility license, such as stipulating the types of family planning methods that must be available, the number of lower-income clients that must be seen, and minimum size requirements (Griffin, 1989).

## **Summary of the Summa Foundation’s Findings on Access to Finance**

While there are a number of useful studies that document access to finance as a constraint to private health-sector development, the research also has some limitations. Most of the literature is based on examples from Africa and is quite dated. In order to mitigate some of these limitations, the Summa Foundation conducted brief assessments in Uganda and the Dominican Republic. Unlike the other surveys cited in the literature review, the Summa Foundation took a different approach by assessing the status of health-sector lending through surveys of commercial banks. Survey questions were designed to analyze the banks’ current health portfolio and determine their level of interest in, as well as potential obstacles to, increased health-sector lending. It should be noted that due to resource and time constraints, the Summa assessments were designed to provide additional information on access to finance; they do not represent a complete review of the banking sector.

### **Findings from Uganda**

To assess the Ugandan banking sector, Summa surveyed six banks on current lending practices and interest in and obstacles to health-sector lending. The six banks included DFCU, Stanbic Bank, Barclays Bank, Citigroup, Nile Bank, and Centenary Rural Development Bank. These banks were selected based on recommendations from the SPEED Project, which is funded by USAID to strengthen small and medium enterprises in Uganda. The banks represent a mix of local, international, and development banks. In addition to meeting with bank staff, Summa also interviewed SME development and finance experts in Uganda for their insights and recommendations.

#### *Current Health-Sector Lending in Uganda*

The assessment revealed that health-sector lending in Uganda is minimal, and is primarily limited to working capital loans to pharmaceutical importers. Only two banks mentioned loans to clinics; both indicated that such loans are largely restricted to the capital, Kampala. Responses to questions on commercial lending terms revealed that most loans are short term — one year or less. Interest rates are currently 22 to 25 percent on Shilling loans, and 8 to 10 percent on US dollar loans. Collateral requirements are relatively strict, with most lenders requiring property located in Kampala. (Secondary property markets outside of the capital are not adequately developed.)

Despite these tight commercial terms, there are several donor programs working to encourage local banks to lend to small and medium enterprises. These include USAID’s Development Credit Authority (DCA) and the European Investment Bank’s (EIB’s) Apex Fund. The DCA is currently

working through seven banks in Uganda. The DCA guarantees up to \$1 million and a maximum of half the loan amount. The DCA encourages banks to take additional risk within the bounds of sound credit decisions. Out of the 70 loans that have received the DCA guarantee (for a total of \$12.5 million), none have been to the health sector. There is no reason, however, that health loans cannot be made through the DCA mechanism. Furthermore, the EIB's Apex Fund is an on-lending program that offers subsidized credit to small and medium-size borrowers. EIB loans, made for 5 to 15 years and currently carrying a 12 percent Shilling interest rate, are the major source of long-term credit in Uganda. While health providers are eligible to participate in this program, they are not doing so in significant numbers.

### *Obstacles to Health-Sector Lending*

When questioned about why their health portfolios were so small, banks cited a number of obstacles. Almost all were wary of making loans in the health sector due to a perception of higher risk and loan officers' lack of knowledge of this market. Bankers stated that their loan officers do not know how to analyze health loans — they do not understand the business model, the cash flow cycle, or how to identify risks as well as opportunities. In addition, collateral is considered a major barrier, especially outside of Kampala. Bankers view health facilities as a highly risky form of collateral. All of the bankers interviewed noted that it would be very difficult politically to seize and liquidate a hospital or clinic. Banks also complained that health providers are typically not good business people. Loan requests by health providers frequently get turned down because of incomplete or unrealistic business plans and inadequate financial statements. Furthermore, many banks cited a mismatch between health providers' financing needs and current bank terms. Under the current short financing terms (excluding donor-backed loans), most providers would be restricted to loans for working capital, inventory, and perhaps some smaller pieces of equipment, as opposed to larger loans for facility improvements or expansion.

### *Opportunities for Health-Sector Lending*

Despite these barriers, all but one of the banks expressed an interest in lending to the health sector, and one bank was very enthusiastic. In general, most of the banks see the private health sector as a growing market, especially if there is a national health insurance program that contracts with the private sector. And there are a number of other factors that bode well for future health-sector lending. For example, a number of banks are increasingly lending to the private education sector, which may make it easier for them to consider additional social-sector loans. And several banks are investing in branches outside of Kampala and thus will be better positioned to consider loans beyond the capital. Furthermore, a number of microfinance institutions are in the process of getting regulated to accept deposits. When approved, these institutions will have more funds available for lending and can consider entering new sectors, including the health sector. Finally, while most of the banks stated that increased health-sector lending is a possibility, they all cited the need for assistance in overcoming the barriers they have identified as currently standing in their way.

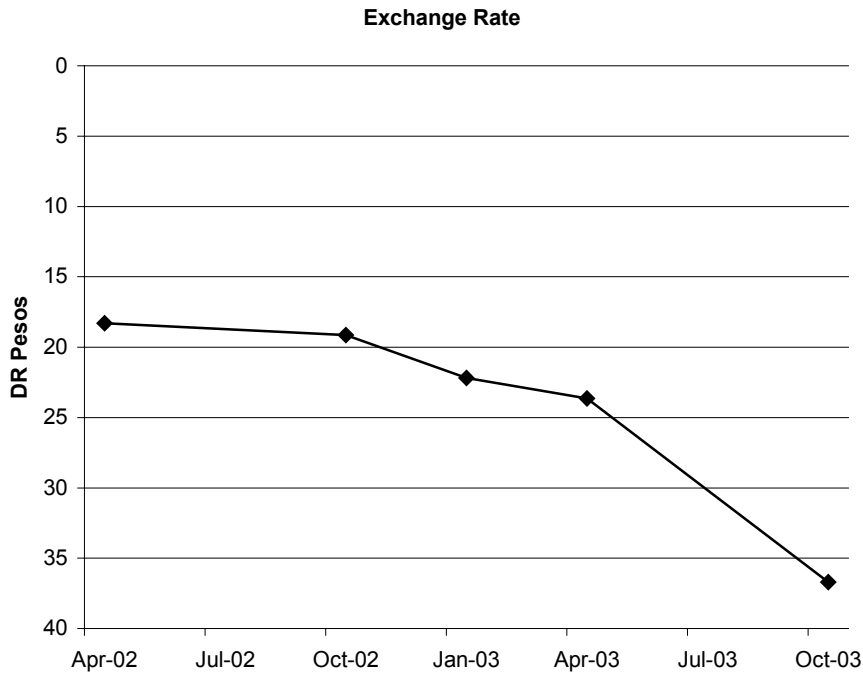
## **Findings from the Dominican Republic**

In order to assess the local banking sector in the Dominican Republic, Summa surveyed three banks regarding current lending practices, interest in, and obstacles to health-sector lending. The three banks included Banco Popular, Banco Mercantil, and Banco del Progreso. A smaller sample was used in the Dominican Republic because the country's banking sector is currently in crisis

and most commercial lending has been suspended. It was decided that additional interviews would not yield significantly different information. In addition to conducting the bank survey, Summa met with USAID/Dominican Republic to discuss the economic condition of the country.

### *Current Health-Sector Lending in the Dominican Republic*

Summa's bank surveys and informal interviews with SME finance experts revealed that banks in the Dominican Republic are not currently lending to the health sector. In fact, the banking crisis means that lending remains severely restricted to all sectors. These banking-sector problems are the result of macroeconomic factors, bank scandals, and government actions taken to stabilize liquidity problems at several large banks. In 2003, real gross domestic product (GDP) was estimated at -3.0 and consumer price inflation (CPI) at 35 percent. Furthermore, the country's currency suffered a significant devaluation over the past year, which has serious consequences for the Dominican Republic's dollarized economy and banks' willingness to lend. The following chart demonstrates the decline, from a relatively stable rate of approximately 17 pesos to the dollar in 2002 to approximately 37 pesos to the dollar in 2003.



As a result of this difficult environment, banking terms are not favorable. Loan maturity is typically short, at one year or less, and interest rates at 35 to 45 percent on peso loans; 15 to 18 percent on US dollar loans. Banks are requiring collateral that is equivalent to two times the real estate value. Since USAID's Development Credit Authority does not operate in the Dominican Republic, banks do not have access to the DCA's loan guarantees.

*Obstacles and Opportunities for Health-Sector Lending in the Dominican Republic*

Currently, the macroeconomic environment and currency situation in the Dominican Republic create major obstacles to health-sector lending: None of the banks surveyed expressed an interest in lending to the health sector for the time being. Thus, efforts to promote health-sector lending in the Dominican Republic will have to wait until the country emerges from its economic and financial crises. While the Dominican Republic represents an extreme case, it was included in this report because it reflects the reality of the developing world: the health sector can face additional problems in accessing financing during periods of economic difficulty. This is in sharp comparison to Uganda, where despite obstacles, there are a number of opportunities to promote private health-sector lending.

## Summary of Findings

This report offers a number of key findings. Most health care businesses in developing countries are either small or medium enterprises, or microenterprises. Like other types of SMEs, health care providers face a number of constraints, including the enabling environment, internal capacity, and access to financing. A World Bank study of SMEs found that in countries where there are many obstacles to growth, SMEs tend to enter the informal sector as a survival strategy (Ayyagari et al., 2003). This finding has grave implications for the private health sector,<sup>10</sup> since the informal health sector in most developing countries is characterized by quality issues, a lack of regulation, and small outlets with limited capacity. Therefore, it is important to remove constraints in order to prevent private health providers from migrating to the informal sector.

Another key finding is that like other types of SMEs, private health providers consider financing to be a major constraint to growth. This finding is supported by provider surveys in Kenya, Tanzania, Senegal, Zambia, and Ghana. Furthermore, the Summa Foundation's assessments of the banking sectors in Uganda and the Dominican Republic indicate that commercial lending to health providers in these countries is minimal, with most banks reluctant to lend to private health sector.

This paper has also found that private providers share many of the same barriers to financing as other types of SMEs, including high interest rates, poorly developed business plans and financial statements, and inadequate collateral. This paper contends, however, that because of the special nature of their business, access to financing is even more of a problem for private health providers than for other types of SMEs. One of the greatest hurdles is collateral. While most SMEs struggle to meet banks' collateral requirements, health providers are at a particular disadvantage because bankers view health facilities as a highly risky form of collateral. Most banks would find it politically difficult to seize and liquidate a health care facility.

In addition, many banks complain that SMEs are difficult to lend to because they are informationally opaque due to inadequate business plans and poor financial statements. Despite this problem, at least most SMEs are run by entrepreneurs that may or may not have a business background. In comparison, many private health businesses in developing countries are owned and run by clinicians with no business experience. Business plans and financial statements submitted by private health providers are frequently considered unbankable.<sup>11</sup>

Another barrier is loan officers' limited understanding of SMEs in general and SME lending in particular. While there are a number of donor-sponsored programs working with banks to increase this understanding, many programs focus on lending to manufacturing or agricultural SMEs in order to have the greatest impact on job creation and economic development. None of the programs reviewed focused on health-sector lending. Typically, banks do not understand the health sector and are uncomfortable lending to it. For example, the Summa Foundation's Uganda assessment revealed that loan officers do not know how to analyze health loans: They do not understand the business model or the cash flow cycle of private health-sector borrowers. They also do not know the risks they need to avoid or how to identify opportunities. As a result, loan officers are reluctant to lend to the health sector.

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<sup>10</sup> In designing the Uganda Private Providers Loan Fund, the Summa Foundation found that a significant number of midwives had opted to set up unregulated drug shops run by untrained staff in order to avoid the expense of opening a regulated midwifery practice.

<sup>11</sup> The Summa Foundation has found that it must provide a considerable amount of technical assistance to private providers to produce business plans and financial projections that are accurate, realistic, and bankable.

All of these factors constrain access to finance. It is one thing, however, for an SME or private provider to report that financing is a constraint. A more important question is whether lack of financing actually does constrain growth. Another key finding of this paper is based on World Bank research showing that the lack of access to financing does significantly and negatively affect an SME's ability to grow and scale-up (Beck, 2002). This finding was supported by a number of research studies in this paper's private health-sector literature review, which revealed that lack of financing can result in limited scale and quality concerns.

The establishment of small, organizationally simple health facilities due to the reliance on self-financing is a theme that runs throughout most of the literature. For example, a review of research in four African countries (Kenya, Tanzania, Zambia, and Senegal) done for the USAID-funded Data for Decision Making Project found that without credit to expand, the private health sector is dominated by small clinics. Credit constraints mean that many providers are self-financing, relying on personal savings and capital from friends or family. The Kenya country study found that without access to capital, many providers are deterred from establishing a private practice. And the Ghana study showed that private practices tend to be small outpatient facilities supporting one physician. These findings suggest that when access to credit is a problem, private providers are typically small in scale. Their ability to scale-up into more organizationally complex forms, such as group practices, franchises, or networks, is limited. And a review of factors affecting the development of private health care provision in developing countries found that the more complex the health care organization, the more dependent it is on capital to grow (Berman and Rannan-Eliya, 1993). This finding has significant policy implications for donors and governments interested in working with the private health sector to achieve scale through more organizationally complex forms, such as franchises and networks.

In addition to scale, lack of access to credit can also result in quality concerns. Without access to credit, providers may struggle to meet government standards and maintain quality. The Tanzania study found that as a result of credit constraints, most providers limited themselves to establishing small dispensaries and pharmaceutical outlets. The survey revealed that these one- or two-room clinics typically did not meet Ministry of Health standards, raising significant quality concerns.

Another important finding is that programs that invest in the private health sector can have positive development outcomes. For example, in the Philippines a government-sponsored loan program resulted in increased private-sector investments in under-served lower-income regions. A study of the program, "Strengthening Health Services in Developing Countries Through the Private Sector," (Griffin, 1989) recommends that governments and donors consider supporting programs such as loans to private hospitals, if the private sector is able and willing to provide services at a lower cost than the public sector. Under such programs, the government can use its regulatory function to ensure that public health outcomes are achieved.

## Conclusion

This paper recommends that governments and donors support improving access to financing to the private health sector. Lack of access to finance can result in a private sector that is dominated by small clinics with limited capacity. Reliance on self-financing can also lead to serious quality concerns. Furthermore, lack of access to finance, in combination with other constraints, such as the limited business capacity of health care providers and a difficult enabling environment, may result in a migration to the informal sector, compounding concerns about quality and scale. Supporting access to finance for the private health sector is an intervention that can be borrowed from the SME development field and used to achieve public health outcomes.

This paper also recommends further exploration of the barriers that constrain access to finance for private health providers as well as the design of appropriate interventions that adapt lessons learned and best practices from the SME development field to overcome these barriers. While this paper has focused on access to financing for small and medium private health providers, access to financing is also an issue for micro health enterprises, including midwives, nurses, and drug shops, which play an important role in the private health sector. This paper recommends that future programming also include interventions to increase access to financing for micro health providers.



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