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What is the impact of improved access to finance for healthcare facilities in Kenya?

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Introduction

The Covid-19 pandemic has brought to the forefront the need to strengthen healthcare ecosystems across the globe, and especially in developing countries. Across the African continent, hundreds of millions of people still lack access to basic healthcare, and public systems alone are not able to bridge this gap. With a growing private healthcare sector in these countries, investment capital will continue to be vital to its development, to complement and support the public health sector, and to build inclusive healthcare ecosystems.

As the UK's development finance institution, CDC is firmly committed to enabling the development of inclusive healthcare ecosystems and improving health outcomes across Africa and South Asia. The Covid-19 pandemic, and the challenges it has posed to health systems across the world, has demonstrated how strengthening healthcare systems is a pressing global priority. The role of private sector healthcare within these countries varies depending on the role that the public sector has taken in healthcare provision, and how national health insurance programmes and healthcare ecosystems are being shaped. The United Nations' Sustainable Development Goal 3 is to ensure healthy lives and promote well-being for all, at all ages. But an estimated investment shortfall of $6-7 billion is hampering low and middle-income countries from achieving this goal. Leveraging private sector capacity, investment and innovation is therefore crucial to supplement public sector efforts and achieve the goal of universal health coverage.

In line with our overall healthcare strategy goal of enabling the development of healthcare ecosystems and improving health outcomes in Africa and South Asia, in 2017 CDC invested in the Medical Credit Fund (MCF), a credit financing agency in Africa under the PharmAccess Group. The investment was made to increase access to quality healthcare for underserved populations, through building scale and quality across the healthcare value chain. MCF does this by offering access to financing to healthcare providers and other institutions across the healthcare value chain that often cannot get funding from the traditional banking sector in these countries.

This study, commissioned and completed before the Covid-19 pandemic, highlights the need to continue supporting the private healthcare sector in Africa, and reveals the financing gaps that are preventing access to quality healthcare provision. It also points to some specific lessons learned for investors focused on private sector healthcare on the African continent, highlighting not only the importance of providing flexible financing, but also building capacity to drive improvements at the healthcare provider level.

Our findings are even more relevant now that healthcare clinics are facing unprecedented strains. MCF is supporting private healthcare providers with flexible loans at a time when they are most needed. Many clinics have seen revenues decrease as patients avoid going to healthcare facilities out of fear of infection. At the same time, providers need to purchase personal protective equipment (PPE) to shield their staff and the community and require working capital to weather the storm. MCF's digital loan products have proven of great value to clinics in a time when many banks are closed. As investors and partners, we look forward to supporting MCF through and beyond the crisis.

Contents

Acknowledgements

This brief was written by Jesse Baver (Dalberg Advisors), Claudia Simler (CDC) and Julia Tobias (CDC) and is based on research conducted by Dalberg Research. We thank Medical Credit Fund (MCF), PharmAccess Foundation, and SafeCare – all part of the PharmAccess Group – for their collaboration with the study. Martina Castro, Michael Sanni, Noorin Mawani, and Alex MacGillivray at CDC also provided inputs.

In 2017, CDC invested $10 million in MCF, a fund dedicated to financing small and medium-sized healthcare facilities in Africa, as a long-term loan. The investment aims to increase access to quality healthcare for underserved populations, through building scale and quality across the healthcare value chain. This type of investment helps CDC support smaller health facilities that we would otherwise not be able to reach directly.

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Overview

Medical Credit Fund (MCF) has a mission to improve access to quality healthcare in Africa and envisions a world where everyone is connected to affordable healthcare. It does so by providing credit financing to small and medium-sized (SME) health facilities across selected countries in sub-Saharan Africa.

Approximately 50 per cent all healthcare services in Africa are delivered via the private sector, with private healthcare provision covering a wide range of income groups, from low-income to high-income. While governments have an important role to play in the healthcare sector, the capacity of governments to finance, regulate, and enforce health policies and services is limited in many countries across sub-Saharan Africa. The region has 3 per cent of the world's health professionals serving 11 per cent of the world's population. Sub-Saharan Africa carries 24 per cent of the world's disease burden with healthcare expenditures averaging around $100 per person per year, about half of which represents government expenditures.[1] Private health expenditure is mostly out-of-pocket.

In Kenya, MCF's largest target market and the geographic focus of this study, there are a total of approximately 10,000 health facilities. About 48 per cent of these facilities are owned by the public sector, 38 per cent fall under private sector ownership and the remainder are owned by faith-based organisations, non-government organisations or community-based organisations.[2] Against this backdrop, an estimated 400,000-plus households are still unable to seek medical care due to lack of financial means, insurance to access healthcare, and poor primary health penetration and significant capacity gaps in secondary and tertiary healthcare. At many of the smaller health facilities across the country – public as well as private – Kenyans face low quality of care, insufficient number of clinical staff, limited medical equipment and drug stock-outs.

38%

of healthcare facilities in Kenya are in the private sector.

Small private clinics play an important role in the overall healthcare system. Yet, they are often unable to access credit due to the perceived high credit risk related to their small size, low profitability, inadequate accounting systems, and lack of collateral. A large percentage of the Kenyan population lives in rural areas and urban slums where public facilities may not be available, and where major access and equity issues exist for health services. This is where the private sector is able to play a key role at multiple delivery levels.

Credit providers such as MCF seek to plug the financing gap experienced by private-sector healthcare facilities by enabling access to affordable finance. MCF's mandate is to build the private healthcare value chain in sub-Saharan Africa, enabling healthcare companies to increase and improve their quality, scale, and efficiency, while better serving a wider range of patients. The estimated total number of patient visits per month for active MCF clinics is currently more than 430,000 and 56 per cent of patients come from low to very low-income groups. Since its inception, MCF has reached an average of 5.3 million patients per year via its network of clinics. Overall, 87 per cent of health SMEs financed through MCF are located in urban and semi-urban areas, with 13 per cent in rural areas.[3]

56%

of patients at MCF clinics come from low to very low-income groups[4].

By helping private healthcare facilities access loans, MCF helps clinics which often would not otherwise be able to get finance make important investments for growth and improvement. MCF provides clinics with more flexible conditions than banks, for example when it comes to collateral requirements, thus eliminating many of the upfront hurdles associated with traditional bank loans. In addition to credit financing, MCF offers clinics targeted technical assistance (TA) through SafeCare, an initiative from PharmAccess, the Joint Commission International (JCI) and the Council for Health Service Accreditation of Southern Africa (COHSASA) that has developed clinical standards for low- and middle-income countries.

1 World Bank (2017).
2 Kenya Master Health Facility List
3 Convergence (2019): Medical Credit Fund Case Study
4 MCF Annual Report 2019

Through interviews with over 110 healthcare facilities across six regions in Kenya, combined with historical data records, this Insight study examines the impact of MCF's credit financing and TA on business and clinical outcomes at its healthcare facilities in Kenya. It focuses on the role credit financing can play in strengthening a healthcare system that is severely underfunded and lacks the capability to respond optimally to a growing healthcare burden in Africa. The study was conducted by Dalberg in partnership with CDC, PharmAccess Foundation, MCF and SafeCare[5] and adds to previous work conducted on the impacts of PharmAccess' work such as a recent study by the London School of Hygiene and Tropical Medicine on the impacts of SafeCare on clinical quality of care in Tanzania.[6]

Key insights from the study include:

- **Providing access to finance:** Our study suggests MCF loans are an important source of finance for healthcare facilities. The typical MCF clinic in our survey took on a loan from MCF equivalent to 26 per cent of average revenues in the year before beginning work with MCF. For clinics with MCF loans as well as those without, there was generally little other funding available. Two-thirds (67 per cent) of the 35 MCF-supported clinics sampled reported no sources of finance other than MCF, and on average MCF funding made up more than 80 per cent of their total financing. Only a quarter (25 per cent) of clinics without an MCF loan reported being able to access other sources of financing, confirming the large gap SME healthcare facilities experience in accessing credit financing.
- **Improving healthcare quality:** Over the past few years, MCF clinics have shown solid improvements in their SafeCare ratings, a proxy for the quality of care and clinic management. Nearly 80 per cent of the clinics examined had increased their SafeCare rating (by an average of 0.3 points on a 1-5 scale per year). While 81 per cent of clinics started out with a rating of 1, at present 48 per cent of the sample has reached a rating of 3 or higher.
- **Increasing patient visits:** Outpatient visits have increased by 20 per cent per annum across the MCF clinics in our study, from an average baseline of 7,255 outpatient visits to over 14,000 outpatients per year currently. Meanwhile, inpatient admissions have grown from an average of 450 per clinic in the baseline year to a current average of 871 inpatient admissions per year.[7]
- **Creating employment:** MCF clinics have also shown strong staff growth, adding on average one full-time-equivalent clinical staff member each year (from a baseline of eight total staff). Of the clinics surveyed, 55 per cent showed positive staff growth, against 24 per cent with no change and 21 per cent with a decline.
- **Growing revenues:** On average, clinics that had received an MCF loan were able to grow revenues at a rate of 6 per cent per annum in real terms (from an average baseline of $390,000 per year).

Overall, the study finds strong improvements on both clinical and business performance within the sample of MCF clinics, which received both loans and TA from SafeCare. We also find similar levels of improvement at the group of clinics receiving SafeCare TA without MCF loans, suggesting a potentially important role for targeted TA in strengthening the capabilities of SME health clinics in providing quality healthcare. Although our study is unable to detect any statistically significant differences between the two groups in the rate of change of our key business and clinical outcomes, we caution that this finding may be due to limitations with the study design and sample size. Further research on a larger sample of clinics (potentially including a control group that has not received either loans or TA) would be required to draw firmer conclusions on the impacts of MCF loans and/or the SafeCare TA provided to clinics.

67%

of the 35 MCF-supported clinics sampled reported no sources of finance other than MCF.

80%

of clinics examined had increased their SafeCare rating.

5 PharmAccess Foundation, Medical Credit Fund and SafeCare are part of PharmAccess Group.

6 London School of Hygiene and Tropical Medicine, February 2020: Addressing Quality in the Private Sector: Findings from an impact evaluation of the SafeCare model in Tanzania.

7 Note that at three MCF clinics, the total number of reported inpatient admissions differs from the total of adult plus child admissions. We have used the smaller of these two numbers when calculating total admissions.

01

Context and MCF's model

At many of the 10,000 health facilities across the country, Kenyans face a general low quality of care, insufficient clinical staff numbers, limited medical equipment and drug stock-outs. Health centres that fall within the private sector (38 per cent) are often unable to obtain financing to renovate their facilities and purchase medical supplies due to their small size, low profitability, inadequate accounting systems, lack of collateral and the overall perception by Kenyan financial service providers that they pose a high credit risk.

MCF was set up in 2009 to offer financing to private healthcare facilities across selected African countries (currently Kenya, Ghana, Nigeria, Uganda and Tanzania), in an effort to address the persistent shortage of capital in the sector. MCF is part of the PharmAccess Group, a non-profit organisation founded in 2001 and headquartered in the Netherlands. PharmAccess is dedicated to improving access to quality healthcare in Africa and has a vision of a world where everyone is connected to affordable healthcare. The organisation's mission is delivered across four dimensions (see Figure 1). With its 18 financial partners, MCF provides various types of loans to healthcare facilities, from larger hospitals to small outpatient-only clinics. MCF lending products include:

- **Cash advance loans:** small loans available quickly through a digital underwriting process on the basis of a clinic's mobile money cash flows. These loans are specific to Kenya.
- **Standard health loans:** available in a wide range of sizes to clinics completing a conventional application process. In Kenya, these loans have been issued in a range of sizes from around $1,000 to in excess of $1 million.
- **Construction, equipment, and pharmacy loans:** designated for specific asset finance, investment, or working capital purposes.

Over the past decade, MCF has disbursed over 4,500 loans worth $80 million to healthcare facilities, with a >96 per cent rate of successful repayment. MCF loans have enabled clinics to invest in facilities, purchase medical equipment, acquire medical supplies and improve their quality of care and operations. In Kenya alone, more than 800 clinics have benefitted from MCF loans to date.[8] In addition to financial credit, MCF provides technical support to clinics to help them improve their overall quality of care provision through SafeCare.

SafeCare delivers TA to clinics (including programmes and training that upgrade the quality of care delivered) and rates and benchmarks the level of quality, safety and risk of healthcare providers. SafeCare collects data using an objective quality assessment methodology focusing on 13 areas in healthcare organisation management, direct clinical care of patients, specialised services and ancillary services and has conducted over 5,600 quality assessments in more than 2,000 clinics worldwide, including more than 1,500 in Kenya. In past surveys, over 80 per cent of facilities reported quality improvement from SafeCare's TA programme.[9]

Loans and business support
PharmAccess has set up a loan and business support programme to help private healthcare providers access financing to improve their perfomance. **Medical Credit Fund** provides loans through financial partners, directly and using digital technology

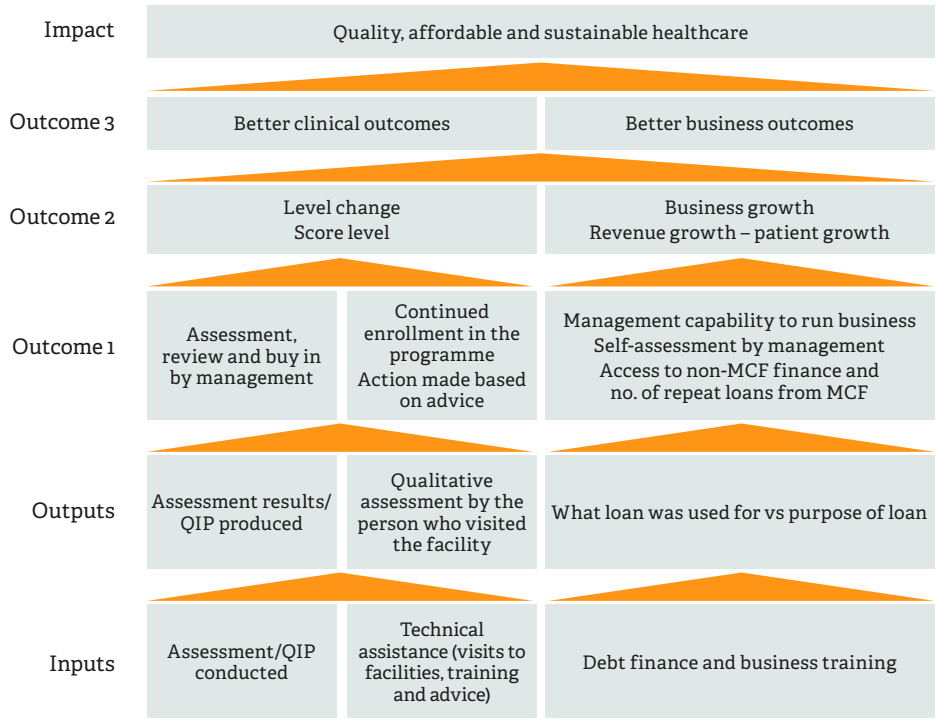
Healthcare Quality Standards
PharmAccess and partners have developed internationally (IsQua) recognised quality standards to assess and benchmark clinical performance of healthcare providers to improve their quality (**SafeCare**)

Focus of this study

Universal health coverage
PharmAccess works with public and private partners to introduce new forms of pre-payment and risk sharing in healthcare using mobile technology. In Kenya, M-Tiba, launched in partnership with telecom provider Safaricom and technology company CarePay, provides access to better healthcare by connecting people directly to healthcare payers and clinics through a health wallet on their mobile phone.

Data to improve health outcomes
PharmAccess uses data to improve health outcomes through independent research and the use of digital technology. It has introduced Care Bundles for expectant mothers (MomCare). Care Bundles are an alternative model for healthcare, designed to improve patient outcomes and quality of care. Using mobile technology, the bundle is a combination of financial access, clinical quality and actionable information to improve and incentivise patient-doctor interaction.

Figure 1: PharmAccess' four main components



Note: QIP is the Quality Improvement Plan developed for a clinic following a SafeCare assessment.

Figure 2: Overview of how PharmAccess delivers healthcare improvements via MCF loans and SafeCare technical assistance

$80 million

MCF has disbursed over 4,500 loans worth $80 million to healthcare facilities.

800

In Kenya alone, more than 800 clinics have benefitted from MCF loans to date.

8 These clinics are part of the approximately 3,800 private healthcare facilities in Kenya.
9 SafeCare, 2020, results retrieved from safe-care.org

02

MCF's impact on health facilities

2.1 Study methodology

The data used for the study were collected and analysed by Dalberg Research and based on field interviews conducted between October and December 2019 with 113 medical facilities across six regions in Kenya (35 receiving both MCF loans and SafeCare technical assistance; 78 receiving SafeCare TA only).[10] Most of the data presented in this report comes from field interviews at the 35 MCF clinics surveyed. The survey data included qualitative and quantitative questions to understand clinic profiles, their satisfaction with MCF, and their business and clinical performance since receiving credit from MCF. We also present some data collected on 78 'non-MCF' facilities that received only SafeCare TA (but no MCF loan). Together, the full sample of 113 clinics served 1.45 million patients in the most recent fiscal year. The sample size is less than initially envisioned for the study due to significant numbers of clinics being unable to participate. While this presents limitations to the analysis, the data still provides useful insights into the clinical and business performance of these health facilities.

Finally, the study incorporates historical data records of 212 medical facilities in PharmAccess' database (107 clinics receiving both MCF loans and SafeCare TA; 105 clinics receiving SafeCare TA only) to examine how clinics improve their SafeCare score over time.[11]

A difference-in-differences methodology was used to compare rates of change on key variables over time at the MCF-supported group with rates of change at the group not supported by MCF. The two groups were roughly balanced in terms of key clinic characteristics such as baseline quality. Therefore, a statistically significant difference in the rate of change over a given time period between the two groups would indicate potential benefits accruing to clinics supported by MCF loans.[12]

10 The sample of clinics was drawn as follows. Starting with a total universe of 422 clinics in Kenya that had received TA support from SafeCare (of which 193 had also received MCF loans), we eliminated clinics receiving their first SafeCare certification before 2013 or after 2018 and initially prioritised the six largest regions of Kenya, resulting in a survey population of 317 clinics (109 with MCF funding and 208 without), of which we managed to reach 113 facilities in total.

11 The universe for this sample was limited to clinics that had received at least two SafeCare ratings between 2013 and 2018, so we could utilise change in SafeCare ratings as a proxy for improvements in clinical performance. 'MCF' clinics were defined as those that received an MCF loan at least 12 months before the most recent SafeCare rating; 'non-MCF' loans include those rated by SafeCare but not receiving an MCF loan or receiving an MCF loan less than 12 months before the most recent SafeCare rating.

12 Technically, different rates of change could also indicate unobserved differences between the two groups that influence the rate of change of key variables (e.g. if one group was located in a faster-growing area of Kenya than the other group). In a small sample dependent on clinics' willingness to participate, we cannot control for all such confounders although we have examined the balance between groups on major dimensions such as size and region.

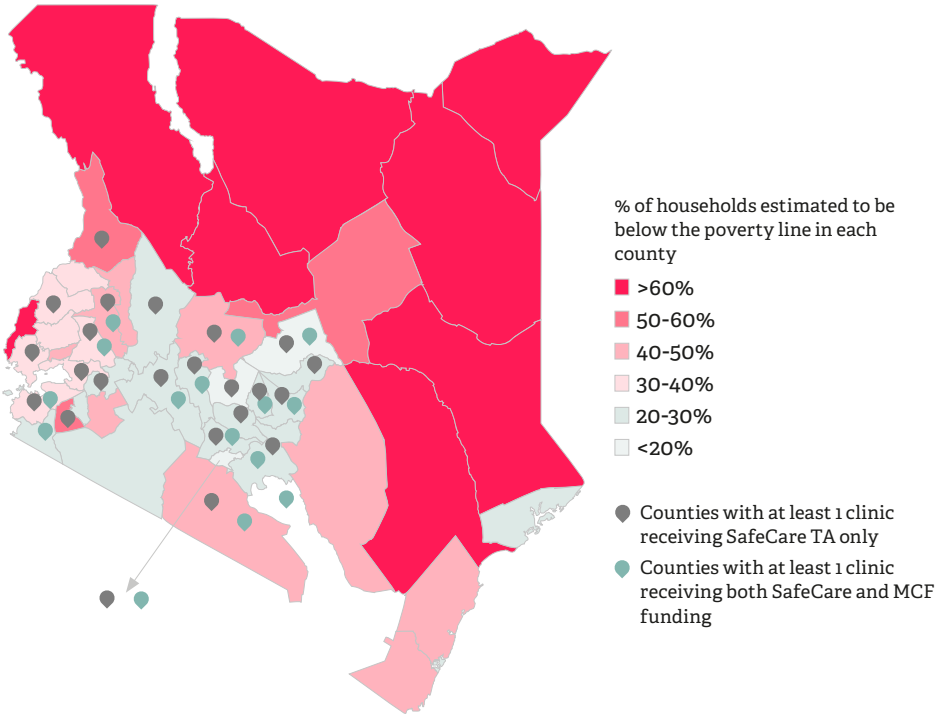


Figure 3: Sampling frame: Counties in which MCF clinics are located in Kenya, including income levels across counties[13]

2.2 What is the profile of clinics receiving MCF support?

Table 1 summarises key characteristics of the 35 surveyed MCF clinics. All of the clinics were from counties in the six highly populated regions of Kenya: Central, Eastern, Western, Nairobi, Nyanza and Rift Valley (Figure 3). The interviewed clinics were either outpatient-only, outpatient and inpatient with speciality services, or outpatient and inpatient without speciality services facilities (none were inpatient-only facilities). For both MCF and non-MCF clinics, 70 per cent had a bed range of ten to 50 beds, placing them in the small- to midsize-facility category for Kenya. This is broadly in line with the type of clinics that MCF serves. Across the sample of MCF clinics, an average of four years had elapsed since facilities received their first MCF loan.

Generally, the data suggest that larger facilities (based on number of beds, patients, and revenues) tend to receive slightly larger loans from MCF. However, this trend does not appear to be very strong overall with a wide range of loan sizes across all facility types within our sample.

Facility characteristics (averages) n=35	
Baseline SafeCare rating (from 1-5 with 5 being the highest rating)	2.23
USD revenue (2019)	390,000
Total staff (full-time equivalents)	8.4
Of which are doctors	2.2
Outpatient visits (yearly)	7,255
Inpatient admissions (yearly)	871

Table 1: Facility characteristics (averages) n=35

13 KNBS, 2018, 2015/16 Kenya Integrated Household Budget Survey Report.

2.3 What gaps are MCF loans filling?

The data suggests MCF's loans are an important source of financing for its partner clinics. Our study finds that the 35 MCF-supported clinics in our sample received an average loan size of ~$80,000 from MCF, with the amounts ranging from $850 to $732,000.[14] This average loan size is equivalent to 26 per cent of the average revenue for these MCF clinics in the baseline year. Of the clinics interviewed, a third received more than one MCF loan. The average interest rate on the MCF loans was reported as 15 per cent p.a.[15], with an average tenor at 38 months.[16]

Clinic revenue in baseline year	Average loan size (USD)	Range (USD)	Percentage of clinics
Not known	$7,000	n/a	26%
Up to $5,000	$11,000	$1,400-$4,700	17%
$5,000-$50,000	$53,000	$850-$282,000	17%
$50,000-$200,000	$19,000	$3,300-$56,000	17%
More than $200,000	$197,000	$4,700-$732,000	23%

Table 2: Average MCF loan size vs clinic revenue (n=35).

As shown in Figure 5, most of the clinics received loans from MCF for capital expenditure purposes: Of these, 46 per cent of the clinics received business expansion or mortgage loans, 40 per cent received asset finance loans and the remaining 14 per cent received working capital loans. Business expansion loans were the largest in average size compared to asset financing and working capital loans. The most common reported uses of MCF loans were for purchasing medical equipment and medical supplies, followed by expanding operations geographically and renovating facilities (Figure 6).

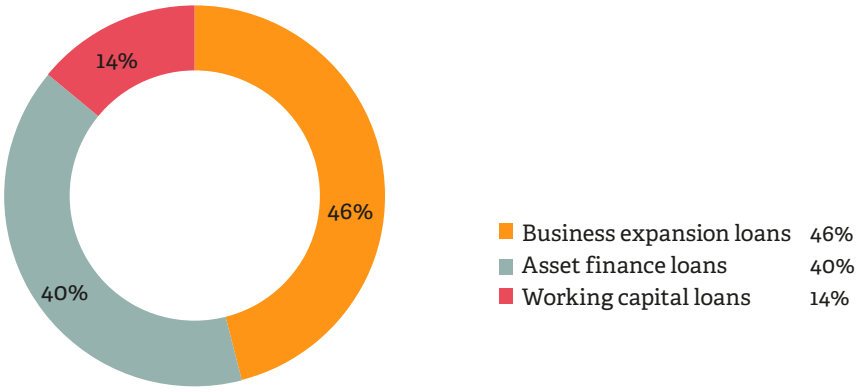


Figure 5: Breakdown of clinics by loan type received from MCF

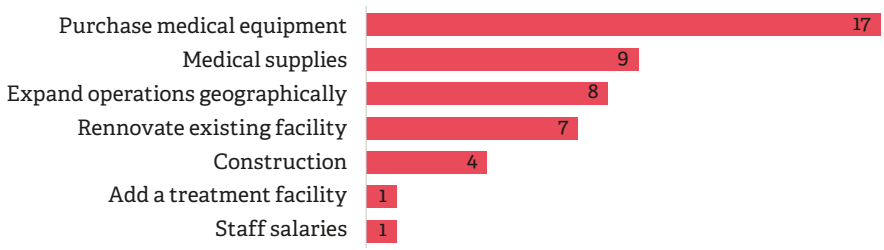


Figure 6: MCF loan purpose (number of clinics reporting each type of use)

14 Note that on average across all MCF facilities taking out loans, the average loan size is $17,000, indicating that the clinics we surveyed received larger than average loans. This could be due to the fact that the selection focused on clinics with at least two SafeCare assessments, suggesting a longer-term engagement, or is simply due to our sample size.

15 Part of the loans were made in partnership with banks, which were subject to an interest rate cap (13-14 per cent).

16 Note: These figures are based on the clinics' reports about their most recent loan and thus exclude some prior MCF loans. A review of MCF central data reveals that for all loans received by these 35 clinics, interest rates averaged ~18 per cent and tenors for closed loans averaged 15 months (around half were for 6 months or less). Maturity to date for open loans has been 25 months on average, although the final maturity date for these loans is not available. Different tenors relate to the fact that the portion of digital loans is higher now.

MCF is the main source of financing for the 35 clinics receiving MCF loans, accounting for 81 per cent of total financing received by these facilities. Among the 35 clinics, 31 per cent have accessed other sources of funding: eight received bank loans[17] and three received loans from informal or other sources of credit (e.g. church groups and savings and credit co-operative societies (SACCOs), independent investors or medical trusts), while 67 per cent of these clinics reported no sources of finance other than MCF (Figure 7). Meanwhile, 67 per cent of clinics that did not have an MCF loan reported no access to finance – evidence of the general lack of financing options for SME healthcare facilities in Kenya. The study did not include any analysis of sequencing to determine whether MCF loans unlocked additional finance, or whether the selection of MCF clinics already favoured the better-performing clinics.

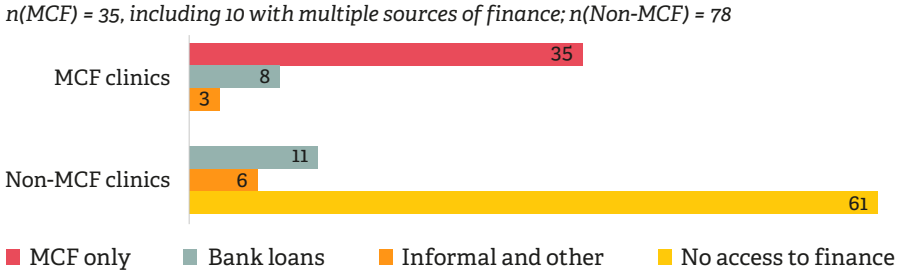


Figure 7: Number of clinics with access to each type of finance

At the facilities receiving both MCF loans and alternative loans (11 out of 35), loans received from MCF tended to be slightly larger than the bank loans received, and significantly larger than informal loans received. Overall, combining all sources of loans received by facilities, MCF clinics were able to borrow ~$88,000 on average while non-MCF clinics (including the 80 per cent with no access to finance) borrowed ~$16,000 on average (Figure 8).[18] If clinics that had no loans at all are excluded, this figure for non-MCF facilities is ~$82,000.

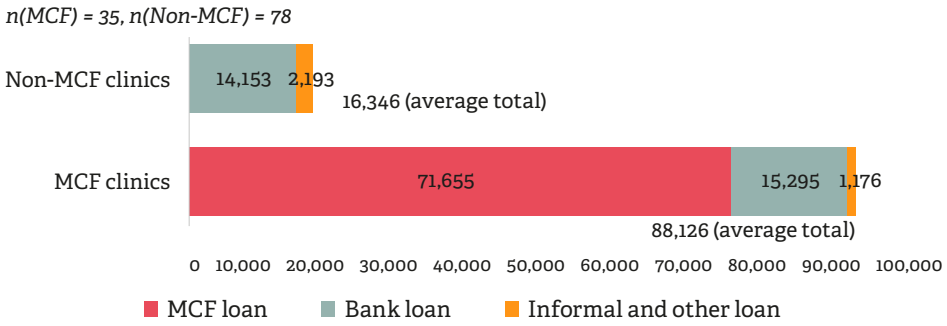


Figure 8: Average amount of loan financing from each funding source per clinic (USD)

17 While some clinics are not always aware of taking on an MCF loan when this happens via one of MCF's partner banks, the 8 clinics in question self-reported both an MCF loan and a bank loan (and gave a variety of specific details on both).

18 Average loan amounts were calculated as total amount of funding for each source divided by total clinics in each group (i.e. 35 for MCF and 78 for Non-MCF) and thus include clinics that did not have a loan at all.

2.4 Impact of credit access on facilities' clinical performance

This section examines how clinics that received MCF funding have performed on key clinical outcomes over time. Our study also compares these outcomes for MCF clinics against clinics that had only received SafeCare TA but no MCF loan. We examine clinical performance through the following proxies:

1) SafeCare ratings to measure compliance against clinical standards across various operational dimensions[19];
2) number of clinic staff;
3) growth in patient numbers; and
4) stock management capabilities.

Overall, the data show clear evidence of improvements along clinical dimensions across the MCF facilities, with similar positive outcomes occurring in clinics receiving TA from SafeCare without MCF loans.

SafeCare ratings

To examine change in SafeCare ratings, our study additionally draws on historical records in PharmAccess' database of 212 health facilities that received a baseline Safecare rating between 2013-2018 and at least one additional rating to enable analysis of change over time (of the 212 clinics, 107 had received both MCF loans and SafeCare TA; 105 had received SafeCare TA only).

Clinics with MCF loans improved their SafeCare rating over time. From the average baseline rating of 1.1 (on a 1 to 5 scale[20]), an average MCF-supported clinic showed a rating and score increase of 0.3 points per year. Of the MCF clinics in Kenya, 79 per cent recorded a rating increase – with 43 per cent recording a rating improvement of 2 points or more – and only 2 per cent recorded a decline in their SafeCare rating. While 88 per cent of clinics started out with no rating (entry level) or a rating of 1, at present 48 per cent of the sample has reached a rating of 3 or higher. Similar results were observed at clinics that had only received SafeCare TA but no loan from MCF, with 76 per cent improving their SafeCare ratings over time. This is consistent with other studies finding the SafeCare model to be effective in improving structural and managerial quality of health facilities, as measured by the SafeCare score.[21]

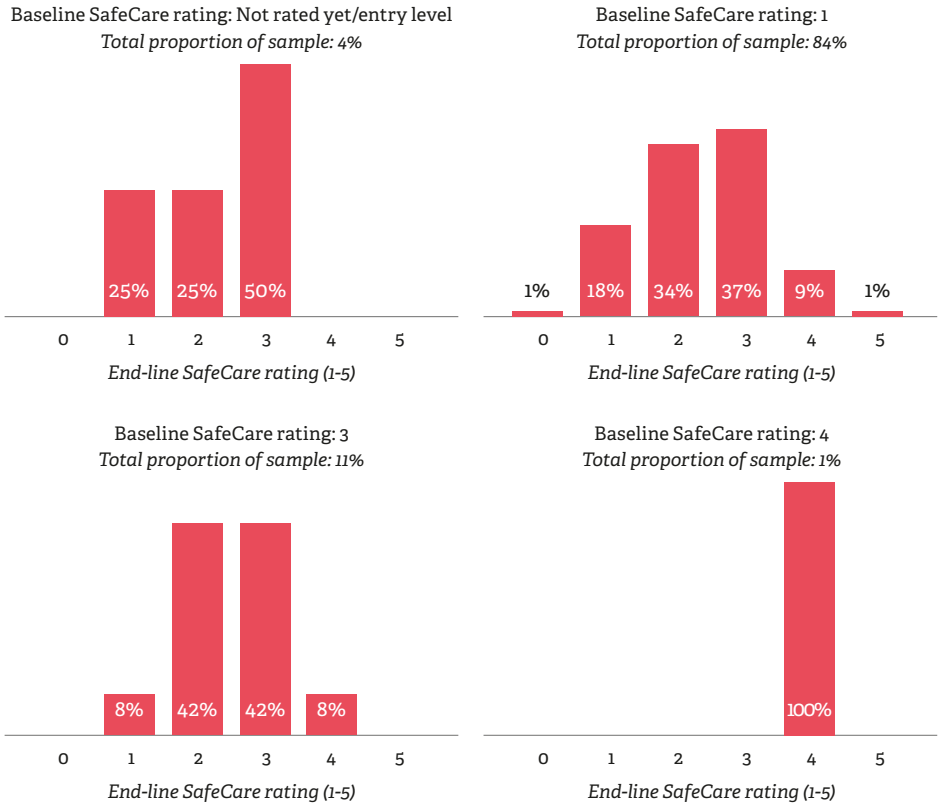


Figure 9: Breakdown of MCF clinics by beginning and ending SafeCare rating (n=107)
(Note: This figure shows the aggregate change from baseline to the present (November 2019 end-line).

19 A SafeCare accreditation process looks at 13 different elements of operational and clinical standards, e.g. 'governance and management', 'outpatient services', 'laboratory services', and 'facility management services' with a total of 170 underlying standards and 640 criteria.

20 No formal rating of zero exists in the SafeCare system, so a "zero" rating in the dataset means that the clinic is entry level/unrated.

21 London School of Hygiene and Tropical Medicine, Feb 2020: Addressing Quality in the Private Sector: Findings from an impact evaluation of the SafeCare model in Tanzania.

About SafeCare

In 2009, PharmAccess, the Joint Commission International (JCI) and the Council for Health Service Accreditation South Africa (COHSASA) developed SafeCare to create international health standards that provide local solutions for low- and middle-income countries. Built on a comprehensive set of (International Society for Quality in Health Care-accredited) quality standards, the SafeCare methodology tracks, acknowledges and certifies quality improvement in a stepwise approach. The methodology is facility-specific, objective and realistic for resource-poor countries, and can be used from small health shops to large district hospitals. SafeCare has conducted more than 5,600 quality assessments in more than 2,000 clinics across 12 African markets (with key markets being Kenya, Tanzania, Ghana, and Nigeria), including 1,500+ in Kenya, some of which are included in this study.

The SafeCare standards cover a full range of medical to non-medical aspects of health service delivery. They enable a holistic view on all required components for safe and efficient healthcare service provision and cover four broad categories: organisational management, clinical services, clinical support and ancillary services, which are divided into 13 categories (service elements). Any issues that impact the safety, quality or financial sustainability of the facility are highlighted as priority areas, so prompt and effective action can be taken to address them. Depending on a facility's performance against the SafeCare standards, it will be awarded a certificate of improvement reflecting the quality level, ranging from 1 (very modest quality) to 5 (high quality), based on their scoring.

The typical SafeCare programme entails a baseline quality assessment which results in a rating and a quality improvement plan, followed by a support visit to discuss these and provide a certificate. The progress on the quality improvement plan is monitored through either in-person visits or remote monitoring. When the clinic has progressed on its quality improvement plan, a repeat assessment is conducted to establish whether this has led to a score improvement.

As of Q1 2020, 1,441 of all healthcare facilities that have received an MCF loan across Africa – or are in the pipeline for a loan – had obtained an approved SafeCare assessment. Larger loans (> $200,000) get a mandatory SafeCare baseline assessment, and follow-up assessment, which also plays a role in the credit appraisal. For smaller loans, due to TA fund restrictions, the SafeCare process is not mandatory, although given the value it adds, some facilities choose to pay for the process themselves.

Clinic staff

We examined the numbers and growth rates of several categories of staff at the MCF facilities, including doctors, nurses, and clinic officers. MCF clinics have added one full-time-equivalent clinical staff member each year on average (from a baseline of eight total staff including two doctors). This growth rate was highest for nurses and is in part driven by a few fast-growing clinics – with the top 9 per cent of clinics adding over four staff members per year. More than half (56 per cent) of MCF clinics showed positive staff growth, against only 21 per cent with declines and 24 per cent with no change. Results were similar in the larger sample of PharmAccess clinics, where clinics added eight clinical staff each year on average and 47 per cent of clinics showed positive staff growth.

Patient visits
The average MCF clinic in our study saw 7,255 patient visits before SafeCare certification but now sees over 14,000 outpatients per year – an increase of 20 per cent per annum. Meanwhile, inpatient admissions have grown from an average of 450 per clinic in the baseline year to a current average of 871 inpatient admissions per year [22]. Again, there were no significant differences in growth in patient visits experienced by MCF clinics compared to the larger sample including non-MCF clinics. As a broader context, it should be noted that overall growth of the population (2.3-2.4 per cent per year) and healthcare needs as well as outpatient coverage made available through the Kenyan National Health Insurance Fund (NHIF) are likely to also be reflected in these numbers.

Stock management
Our study in general found good improvement in stock management practices and systems. MCF clinics with a stock management system in place increased from 60 per cent at baseline to 94 per cent, with 38 per cent of the clinics that had a paper-based system in place at baseline shifting to digital stock management systems. Once again, these improvements were similar in the full sample of PharmAccess clinics where the percent of clinics with a stock management system in place rose from 59 per cent at baseline to 87 per cent at end line.

However, despite the stock management system improvements at these facilities, we generally did not see improvements in stock-out rates of basic products such as vaccines and family planning products with the exception of malaria test kits. This is likely also due to upstream challenges in the supply chain.

2.5 Impact of credit access on facilities' business performance

This section examines the business performance of MCF clinics, focusing on 1) revenue growth and 2) financial management indicators. While there are some data limitations, we generally found that business performance has improved over time. However, our study is unable to detect evidence that clinics receiving credit provision from MCF alongside SafeCare TA perform better than other clinics receiving SafeCare TA without loans, as these clinics see similar improvements in outcomes.

Overall, MCF clinics had an average inflation-adjusted[23] growth in revenue of 6 per cent p.a. (from a baseline average of $390,000 per year), with most clinics displaying revenue growth between 0 and 20 per cent p.a. (Figure 10). These figures are based on the 17 MCF clinics in our sample with revenue data available from the survey. Average revenue growth rates were the same (6 per cent p.a.) across the sample of MCF and non-MCF clinics[24].

While these revenue growth rates appear to be strong, it is worth noting that revenues grew more slowly than the average patient growth rates in MCF clinics cited earlier. This may reflect the increasing number of patients covered by the NHIF, with clinics being paid through a combination of capitation fees and set pricing rather than fee-for-service payments, which may lead to lower revenues per patient for the clinics. Alternatively, it could reflect a differing mix of patients and related differing revenue over time, or financial management challenges, among other possibilities that future research could explore.

It is also worth noting the high variation in growth rates across clinics, with 71 per cent of the MCF-supported clinics experiencing positive growth rates but the remaining 29 per cent showing revenue declines over time. None of the clinics surveyed were able to provide profit (in this case, EBITDA data) at a high enough quality to analyse, suggesting a potential need for further support on financial management and recordkeeping.[25]

22 Note that at 3 MCF clinics, the total number of reported inpatient admissions differs from the total of adult plus child admissions. We have used the smaller of these two numbers when calculating total admissions.
23 We multiplied the nominal revenue for a given year by the ratio between the 2019 average Kenyan CPI (190) and the average Kenyan CPI in the year of the observation, as obtained from the World Bank online Databank.
24 Of the 113 clinics surveyed, only 58 (51 per cent) were able to provide valid revenue data, with similar patterns observed for MCF clinics and non-MCF clinics.
25 As a general caveat, revenue data was not available across all clinics and data was collected retrospectively, which may have led to some inaccuracies.

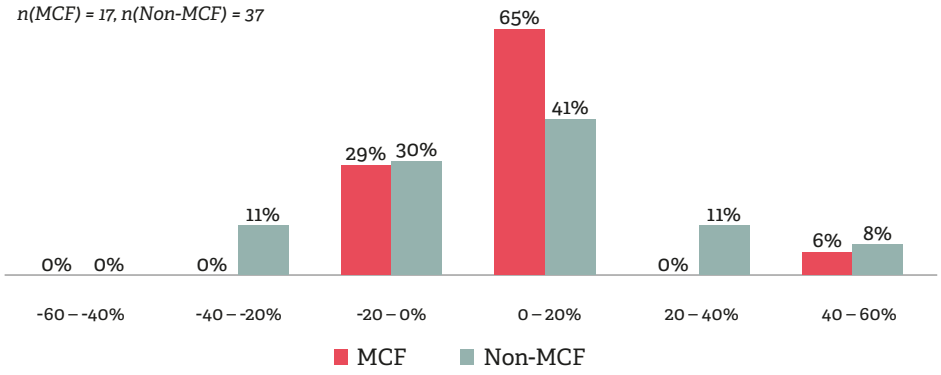


Figure 10: Clinic revenue growth (Compound annual growth rate, %)[26]

To shed light on clinics' skills and capabilities around financial management as a core building block of business performance, our study examined the current status of clinics' financial management tools and comfort with various financial tasks. This highlighted a number of areas where MCF clinics appear to be performing better than non-MCF clinics.

MCF clinics reported having greater comfort with the process of obtaining financing, rating their comfort at 3.7 out of 5, compared with 3.0 out of 5 for the non-MCF clinics in our study, suggesting that working with MCF may have given clinics some long-lasting, transferable skills in this area. MCF clinics also reported better performance in paying employees on time.

Overall, however, the findings highlighted that many clinics still do not rate themselves highly across a range of basic financial management and business skills (Figure 11). On average, clinics rated their comfort in creating annual budgets at 3.5 out of 5, with almost 20 per cent feeling uncomfortable managing this task. Similar patterns emerged for clinics' comfort with applying for financing, on average resulting in a rating of 3.2 out of 5, with almost a third of clinics indicating feeling uncomfortable managing this task.

Adoption of financial management tools remains low and uneven, with most clinics relying on a simple daily cashbook for record-keeping. Only around 40 per cent of all clinics had a formal budget and only 45 per cent had formal accounts (either audited or internal). Given the importance of clinics' financial capabilities in both obtaining loans and maximising the benefits of credit access later on, this suggests an important area for credit providers and technical assistance providers to focus on.

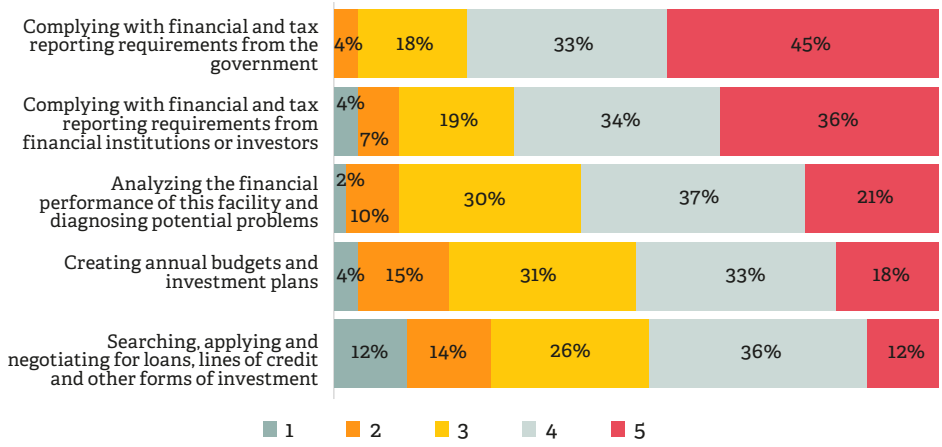


Figure 11: Clinics' self-assessment of comfort level with financial management (on a scale of 1-5, with 5 being the highest degree of comfort), for all 113 clinics (MCF and non-MCF)

26 From the sample of 58 clinics with baseline revenue data (i.e. a revenue datapoint from the year before they joined SafeCare), only 54 provided a second datapoint to enable us to measure change in revenue (thus only 54 clinics reflected in the graphic).

2.6 Satisfaction and challenges

Using a qualitative approach, we explored clinics' overall satisfaction with MCF compared with other sources of lending (e.g. bank loans) and clinics' perceptions of the main benefits of working with MCF. The majority of surveyed clinics perceived their experience with the MCF loan process and repayment procedures more positively than their experience of working with banks. This was the case even though 74 per cent of the clinics reported they were required to provide either bank statements, audited accounts, collateral, outpatient data or information on company ownership to acquire loans from MCF – meaning that in many respects clinics were being asked to provide the same type of documentation as required by traditional banks.

Two-thirds (65 per cent) of surveyed MCF clinics rated their experience working with MCF very positively, rating 4 or higher on a 1 to 5 scale, with most of these clinics highlighting the positive impact of MCF loans. Many stated that they had a better working experience with MCF in terms of paperwork and repayment procedures, particularly highlighting the benefits of a 'lighter-touch' and quicker loan process approach leading up to the credit approval, as well as an easier process of loan repayment via MCF's mobile money repayment system.

> ***They conveniently gave me the loan without a lot of paperwork and the repayments were done via till number instead of the tedious bank repayments.***
> *Clinic with MCF loan*
>
> ***They responded promptly [and] had low demands in terms of security for the loan. They didn't ask for things like logbooks or title deeds – they offered the loan based on what was available in the facility.***
> *Clinic with MCF loan*
>
> ***Process of application for finance is quick and not restrictive compared to banks.***
> *Clinic with MCF loan*

Other responders mentioned that MCF loans enabled them to implement SafeCare's recommendations, or that SafeCare's TA on business management enabled them to acquire loans under better terms.

> ***PharmAccess through MCF has enabled us to expand our operations and improve our service quality. We are able to do scans with the equipment we purchased through the [MCF] loan which we couldn't do before.***
> *Clinic with MCF loan*
>
> ***[The experience] has been very educative…since we had training through [SafeCare] on business management, we've been able to expand our minds in negotiating for loans and was offered loans at a good rate. They've also made us come out of our comfort zone.***
> *Clinic with MCF loan*

Challenges highlighted by clinics generally concerned delayed loan disbursements and strict loan requirements. Some clinics mentioned being quoted a higher interest rate from MCF than from traditional banks.[27] Where clinics provided neutral or negative ratings of their experience, we found a clear concentration among those with smaller loan sizes; comments by these clinics highlighted concerns about approval speed and the complexity of the process.

27 Banks in Kenya have in recent years been subject to an interest rate cap, which can make bank credit more attractive on paper – if an SME can qualify for and obtain a bank loan.

Finally, we asked clinics about their experience with SafeCare's TA and certification as well as their perception of its impact on their clinic (Figure 12). 60 per cent of all clinics gave a positive (4 or 5 out of 5) rating of the overall experience with SafeCare. The top reasons clinics cited for their satisfaction included SafeCare's ability to provide targeted knowledge and training.

The perception of the impact of SafeCare certification on their facility was also positive, with 58 per cent rating the impact as a 4 or 5. The negative ratings generally highlighted communication and follow-up issues, such as how to implement recommendations outlined in the SafeCare Quality Improvement Plan. The perception of SafeCare TA was overwhelmingly positive, with 92 per cent and 69 per cent of clinics reporting that it had a positive impact on their clinical operations and business operations, respectively.

Suggestions for improving SafeCare TA focused on the frequency and regularity of training and follow-ups, which corroborates the findings of recent studies that have examined the impacts of SafeCare.[28] Clinics highlighted issues such as a need for more frequent re-training given staff turnover, a preference for in-facility training instead of classroom training, and broader training for junior staff.

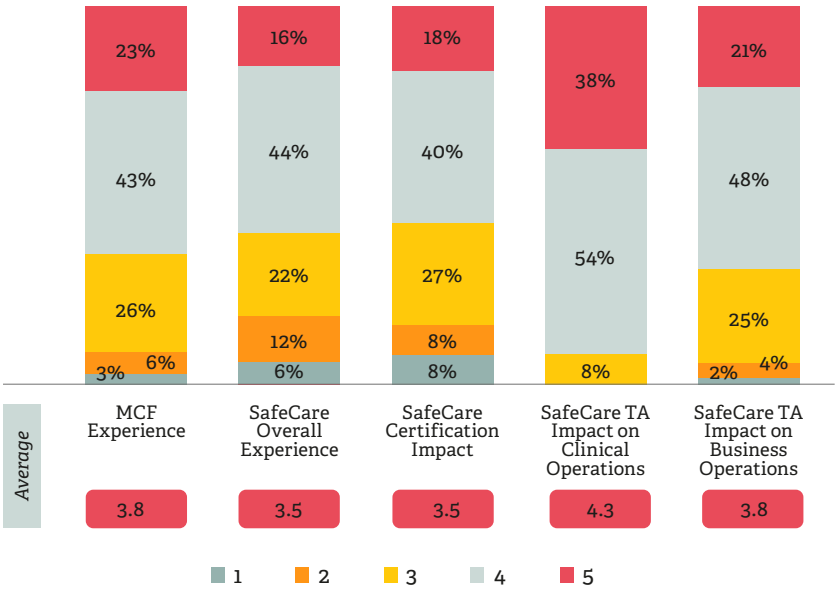


Figure 12: Clinics' experience working with MCF and SafeCare and perceived impact on operations, on a scale of 1-5 with 5 being the most positive[29]

28 London School of Hygiene and Tropical Medicine, February 2020: Addressing Quality in the Private Sector: Findings from an impact evaluation of the SafeCare model in Tanzania

29 For the first three dimensions (clinics' overall experience working with MCF, clinics' overall experience working with SafeCare, and clinics' assessment of the impact that a SafeCare certification has had on the facility overall), enumerators gave the instructions that 1 = lowest score and 5 = highest score. For the last two dimensions, where clinics were asked to rate the impact of SafeCare on clinical operations and business operations, respectively, the following ratings were given as options: 1= not useful at all, 2 = somewhat useful, 3 = neutral, 4 = useful and 5 = extremely useful.

03

The way forward

MCF's model has allowed a previously underserved group of healthcare facilities to access loans to expand and improve their healthcare facilities. Given the massive financing gap in Africa, the MCF model is an important piece of the puzzle when it comes to strengthening African healthcare systems.

Our study suggests that MCF loans are a critical source of finance for healthcare facilities, most of which do not have access to alternative financing options. It shows overall strong improvement – on both clinical and business performance – at MCF clinics that receive both loans and TA from SafeCare. Similar levels of improvement are found at the wider group of clinics receiving SafeCare TA without loans, suggesting a potentially important role for targeted technical assistance to strengthen the capabilities of SME health clinics in providing quality healthcare. Our study is unable to detect any statistically significant differences between the MCF and non-MCF groups in the rate of change of our key business and clinical outcomes, but we caution that this finding is inconclusive and may be due to limitations with the study design and sample size.

More elaborate research on a larger sample of clinics would be required to draw firmer conclusions on the impacts of MCF loans and SafeCare TA. Finally, it is important to keep in mind that the beneficial effects of credit access may take more time to influence clinical and business outcomes, so following these impacts over a longer time period may also be needed. The majority of loans are reportedly used on business expansion/mortgage or purchasing medical equipment – areas where any impacts, if accruing, may take several years to manifest.

Based on the information gathered in this study, some potential recommendations for MCF include:

- Untapped potential for improvement may exist among the population of clinics currently receiving MCF loans without SafeCare TA.[30] While the study set out to test the impact of MCF funding, and not the impact of SafeCare TA itself, the overall strong positive changes observed at all surveyed clinics receiving SafeCare support without MCF loans suggests SafeCare's operational support may have significant benefits for clinical and business performance.
- Exploring ways to automatically bundle credit financing with technical assistance may be important, acknowledging that clinic owners are often cautious to pay the up-front costs here. This will include testing different kinds of loan and TA bundling and/or improving the positioning of TA as a productive investment to clinic owners. Further developing technology-driven solutions to bring down costs and unlock access to TA at lower costs may be equally important, while recognising that specific high-touch interactions will likely be needed to continue to support clinics in their capacity building.
- Providing targeted training on financial management – such as budgeting, accounting, and record-keeping – while supporting facilities to implement best practices could help clinics to manage their finances and growth more effectively.
- Regular and structured data collection efforts should be pursued to track clinic progress over time in a wider sample. Before this study began, only limited data on key dimensions of MCF clinics' business and clinical performance was available. The field survey filled in some gaps, but certain trends still require a larger sample to confirm, and many open questions remain about the role of credit access on both business and clinical performance.
- Data collection is a costly and laborious task and exploring structured, yet easy, ways for better data collection to facilitate loan disbursements and tracking of progress will be important. MCF is already exploring digital channels to address some of the challenges of obtaining clinic data.
- Given its financing structure, which still relies on concessionary capital to serve smaller clinics, it will be important for MCF to continue to explore the most cost-effective strategies to maximise its impact while ensuring financial sustainability. MCF is already taking strides in implementing a more digital strategy for its loan products, for instance via its Cash Advance product in Kenya, whereby MCF provides small (working capital) loans directly to borrowers. Several SafeCare processes are also being digitised, leading to a much more cost-effective way of implementation – for instance, using WhatsApp for clinics to send in pictures as evidence for progress on their quality improvement plans.

30 SafeCare activities are focused on larger loans (> $200,000) with a longer tenure, where MCF's engagement with the clinic is stronger. Clinics who receive Cash Advance loans for working capital or other small and short-term loans are not automatically included in the SafeCare programme. Donor funding is often still required to support TA for smaller clinics. A full SafeCare assessment and first quality improvement plan costs $2,500.

Cash Advance in Kenya

Digital lending can provide an efficient solution for healthcare SMEs in Africa, with rapid turnaround times and no collateral requirements. By digitising loan procedures, lending small amounts becomes cost-efficient and repayments can be automated daily based on real income.

Based on these principles, in 2017 MCF launched a 'Cash Advance' digital loan product in Kenya, offering short-term working capital loans of USD 100-100,000 in local currency equivalents. Repayments are made through automated daily instalments as a percentage of income from mobile money, capitalising on Kenya's 'M-Pesa' revolution. Building on the success of this, a mobile asset finance product was launched, using the same technology to finance the purchase of medical equipment as well as other equipment such as solar panels. These loans have a longer tenure of up to three years.

Lenders apply for a Cash Advance via their mobile phone based on their past revenues paid through mobile money, and repayments are deducted automatically from their mobile income. In this sense, Cash Advance has a unique structure: the repayment of the loan – and thus its tenor – is dependent on the actual income of the healthcare SME.

So far, MCF has disbursed more than 2,000 Cash Advances in Kenya with a total volume of USD 13 million and a customer retention rate of more than 70 per cent and a 96 per cent repayment rate. This demonstrates a clear demand for the product and shows that lending based on mobile money flows without collateral can be deployed safely.

The success of digital lending products, initially developed in Kenya, such as Cash Advance and its spinoff Mobile Asset Finance, has encouraged MCF to develop similar digital loan products for other countries, focusing on loan products with lending based on digital cash flows and working with health insurance companies and banks. This strategy could be essential to serving healthcare SMEs in the best way possible.

Moving forward, continued efforts by development finance institutions, private investors and donors are important to identify and address barriers to finance faced by smaller health clinics otherwise shut out by formal finance. This includes providing more accessible loan options and using digital solutions that make credit appraisals easier, along with cash-flow based solutions that do not require collateral. Lending should be coupled with adequate focus and investment into targeted technical assistance where needed.

Strengthening both clinical and business performance for a broader set of healthcare facilities across the African continent relies on financing providers building significant scale in their operations and reach. Furthermore, providing simple yet powerful bundling of financing and technical assistance will be needed to upgrade the ability of African clinics to serve the millions of patients who are in dire need of quality healthcare provision.

We hope the learnings captured in this report will be useful for MCF, as well as for other players operating within the private healthcare space that are working to increase credit access for smaller healthcare providers across emerging markets.

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