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**Building Linkages
between the
Microenterprise and
Health Sectors:**

An Issues Paper

GEMINI

GROWTH and EQUITY through MICROENTERPRISE INVESTMENTS and INSTITUTIONS
7250 Woodmont Avenue, Suite 200, Bethesda, Maryland 20814

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Building Linkages between the
Microenterprise and Health Sectors:
An Issues Paper

by

Lori Ann Olson
Development Alternatives, Inc.

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This issues paper is intended to share information about the emerging linkages between microenterprise and health programs and offer alternatives and ideas for program/research interventions. I would like to challenge the reader to take something from this exploration of cross-sectoral linkages and really "do something about it" in his or her daily work. Any opinions and errors contained within are entirely the author's.

INTRODUCTION

Despite progress in the developing world in the areas of economic development, literacy, and disease reduction, expanded quality health care remains elusive. Developing country governments are faced with growing demands for health care services, but clinics and hospitals are often bureaucratic, inefficient, and underfunded. Limits to donor funding, as well, are prompting efforts to identify ways to increase private sector provision of health care services and enhance the cost-effectiveness of health care delivery.

In its 1993 *World Development Report*, the World Bank advocated a threefold approach to health reform in developing countries: (1) economic growth to ensure income gains for the poor; (2) reductions in specialized care in favor of a cost-effective "package" of public health care services; and (3) greater diversity, deregulation, and private sector competition in the delivery and financing of health care services (World Bank, 1993, p. iii).

Identifying linkages between microenterprise and health care programs should offer significant potential to improve the provision of basic health care services through the private sector. Lessons learned in microenterprise programs could be applied to help improve health care delivery and develop payment mechanisms that are more flexible than the traditional "fee for services" method, such as emergency savings and loan services.

This paper is designed to clarify the areas of overlap between the fields of microenterprise development and health, identify program options and related issues, and recommend research topics to identify where the greatest progress can be made toward achieving mutual program goals. These steps will advance the process of more fully integrating microenterprise development into the operation and economic growth strategy of the U.S. Agency for International Development (USAID).

The microenterprise development field brings three hard-won lessons to the table. First, the field has successfully developed broad networks of financial institutions providing credit and savings services to the poor on a replicable and financially sustainable basis. Second, the field has found ways to develop successful, sustainable linkages with groups of people who need and can pay for health care services. Third, microenterprise practitioners have developed finance, management, and market analysis methodologies and training methods to support income-generation and credit and savings programs.

Practitioners from the health sector bring four important lessons to the discussion. First, they have long-standing experience in the development and provision of primary health care and family planning services. Second, they have rich experience with a vast array of financial mechanisms for delivering health care, ranging from public sector subsidized activities to private for-profit programs. Third, health practitioners have research experience and methodologies to improve the measurement of the social impact of projects, such as the relationship between credit, income, and health and nutrition, a focus which to date has been lacking in the microenterprise field. Finally, health practitioners have made linkages with existing health care providers in newly liberalized markets.¹

In order to evaluate which program areas offer the most potential for collaboration and impact, one must first identify the cross-sectoral issues and interventions associated with microenterprise and the health

¹See Annex A for a summary diagram of the relationship between the two sectors.

care field. These can be found at two broad levels: demand-side interventions and supply-side interventions.

- **Demand-side interventions** focus on stimulating consumer demand and the ability to pay for health services through increasingly responsive and flexible financial services, as well as education/marketing and income-generation programs to enhance consumer awareness and purchasing power.
- **Supply-side interventions** are directed toward increasing the efficiency and management of existing health care providers and creating new health-related enterprises.

Considering the nature of the health sector in developing countries, the expansion of the market as a whole can be achieved through carefully selected interventions on the demand and/or supply side. The following sections describe these interventions in more detail and identify program linkages in terms of "what we know" and "what we don't know," including relevant project case studies and lessons learned, key issues to address, and future microenterprise/health opportunities worth exploration.

DEVELOPING DEMAND-SIDE INTERVENTIONS

Project interventions in a sufficiently liberalized marketplace can have a significant impact on consumer demand, contributing to the viability and sustainability of the health sector as a whole. Consumers have been shown to be willing to pay for private health services of perceived quality even when public services were available (LaForgia and Griffin, 1993, pp. 30, 84; Litvack and Bodart, 1993, p. 381). This correlation is consistent with microenterprise lessons learned regarding the ability and willingness of the poor to pay for credit services. On the demand side, programmatic options for potential health and microenterprise interventions include the continued development of flexible financial (credit and savings) services, and social marketing and education to "create" or stimulate demand.

Financial Services Development

The structure, cost, and availability of financial services for health care payment are essential to the effectiveness and efficiency of health care delivery systems. Many clinics and private health care services still charge traditional fee-for-service fees, which must be paid at the time of delivery. This method, combined with the low quality of "free" government services, has often meant that informal sector entrepreneurs have either borrowed funds from family sources or traditional moneylenders or have decapitalized or sold out important business assets to pay for health care. As a result, the development of financial mechanisms to serve these clients on a more flexible basis over time will contribute to the economic health and well-being of the household.

Cross-sectoral interventions to develop and expand microfinance services incorporate the following goals: (1) increase incomes and consumer buying power for health services, and (2) increase access to new payment mechanisms beyond the fee-for-service approach.

Incomes and Buying Power

Because user fees are becoming a necessary part of sustainable health care systems and access to services has often been limited by financial constraints, income-generation activities, particularly those aimed at women, can be the first step to increasing the ability of the poor to pay for health care.

Relationship between Income and Health. According to the World Bank, the relationship between income and health is causal, and increased national incomes lead directly to better health (World Bank, p. 41). On the microeconomic level, results may be less directly linked, but a positive relationship has been demonstrated. In "Paths to Household Food Security: The Role of Credit to Women," for example, Shirley Buzzard concludes that women's credit programs have a positive effect on income and household nutrition when associated with other health services, nutrition education, and women's ability to control spending (Buzzard, 1995, pp. 27-28). This correlation is based upon research conducted through the USAID Office of Health and Nutrition IMPACT (Food Security and Nutrition Monitoring) project regarding the impact of microenterprise credit programs on household nutrition.

Studies of the Grameen Bank and other income-generation programs in Bangladesh have shown a positive association with women's empowerment and contraceptive use (Schuler and Hashemi, 1994, p. 65; Amin, et al., 1994, p. 555; Dearden and Khan, 1994, pp. 8-10). Additionally, nongovernmental organizations (NGOs) such as Save the Children and Project Hope use rural interventions that integrate components such as health, income-generation, and environment. The World Health Organization (WHO) also acknowledges a positive relationship between credit and health education programs; however, it notes that "more general research is also needed on the monitoring and evaluation of the health impacts of credit schemes" (World Health Organization, 1994, p.12).

Importance of Women's Role. Despite the challenges of pinpointing the health impact of microenterprise programs, one lesson is clear: The impact is very much related to women's dual role in the household and the enterprise. The experience of the Growth and Equity through Microenterprise Investments and Institutions (GEMINI) Project indicates the importance of women's economic activities to household income levels. Women's impact on family health is equally strong because women tend to be the primary users of health services (for example, for curative and child care) and are responsible for preventive care, such as food preparation and family hygiene. As a result, the role of women in microenterprise and health should always be at the forefront of program strategic goals and implementation plans. Cross-cutting strategies to support women's contributions to family health and income include: (1) reducing women's time conflicts (by improving home and/or market productivity); (2) increasing women's incomes; and (3) improving women's education (Leslie, et al., 1986, p. 334).

Beyond the role of women, the presence of other external factors obscures the exact nature of the relationship between income and health at the household level. USAID and the Small Enterprise Education and Promotion (SEEF) Network plan further research to clarify this relationship and identify the key issues and program approaches needed for success. As a result, the main focus of the following section will be on the development of new health care payment mechanisms through microenterprise credit and savings channels, which may offer more immediate and measurable results.

New Payment Mechanisms and Microfinance Institutions

In the area of private sector financing and the development of new payment mechanisms, microenterprise institutions and expertise can make significant contributions to the health sector.

Considering that many health and microenterprise programs share the same target audience — the poor and the informal sector — sharing financial systems and expertise may be one means to enhance project impact and cost-effectiveness in both areas.

Today, established microfinance institutions are in operation with millions of clients. The microenterprise field has proven that the poor can and will repay loans, and that microcredit programs can be implemented at scale on a financially sustainable basis. USAID's Health Finance and Sustainability (HFS) Project has been in operation for more than five years and has evaluated private sector health care financing options such as public/private sector collaboration, health insurance schemes, managed care options, prepayments, regionalized ministry of health services, and nonprofit health care providers.

Three high-potential areas have emerged with regard to new payment mechanisms:

- Piggybacking health prepayments with microfinance institutions;
- Sharing revolving loan funds for microenterprise and health; and
- Combining microenterprise credit components with health components.

Given their apparent potential for success, each of these is examined separately below.

Piggyback Prepayments with Microfinance Institutions. This concept suggests linking local microfinance institutions (whether NGOs, credit unions, or others) with qualified local health care providers to develop a managed care system. In the Dominican Republic and Ecuador, local health care providers have explored the possibility of linking with lending associations (such as ADEMI) serving informal sector microenterprises (LaForgia, 1990, pp. 25-27).^{2 3} However, such types of "insurance" schemes remain difficult to develop. "The growth of a voluntary health insurance industry among informal sector workers is hampered by the low, irregular income structure of the majority. The provision of free hospital services by the government also reduces the risk of catastrophic illness and thus limits the population's need to insure" (LaForgia and Griffin, p. 163).

There are a few examples of slight variants on this model, such as USAID's project Kenya (which linked health care with organized labor groups and cooperatives), USAID's TIPPS and Family Planning Enterprise Projects (which have experience with "demand creation" for family planning services through medium- size and large enterprises), and health maintenance organizations (HMOs) (Logan, et al., 1989, pp. 21-24). These projects indicate that, at least in the specific markets identified, health systems can be added to nonhealth systems. However, until now, there has been little experience linking health care providers directly to microfinance institutions.

Revolving Loan Funds. The second potential role for microfinance institutions in the provision of health care would be to share revolving loan funds in order to increase the productive utilization and investment of funds. Charles Meyers suggests this approach to enhance Thailand's primary health care (shareholder) system, which is based upon traditional savings clubs and utilizes Ministry of Health start-up capital (LaForgia and Griffin, p. 40-41). Other variations of these models may also be possible in order

²Asociacion para el Desarrollo de la Microempresa, Inc. (ADEMI) is a successful nongovernmental lending program providing approximately 10,000 loans a year to microenterprises (average loan size, US\$450). ADEMI does not mobilize savings (Otero and Rhyne, 1994, p. 207).

³See Annex B for a description of the model.

to incorporate existing microenterprise financial mechanisms into developing country health care systems. However, project experience with revolving loan funds has been mixed. There are numerous examples of failed or unsustainable loan funds (particularly in the NGO community) that were attached to health programs without proper financial management and planning (Olson, 1995).

Microenterprise Credit with a Health Component. Integrating health components as part of microenterprise credit programs is another option encompassing both demand creation and the supply of health information and care. In a 1994 joint WHO-IBRD (World Bank) workshop, "Banking for Health," WHO identified several credit programs that have been effective at reaching the poor through the introduction of "...health components which have become part of the criteria for loan eligibility, disbursement, and savings" (World Health Organization, p. 4). These health components include functional literacy, primary health care education, family planning services, improvements in hygiene, and water and sanitation facilities.

Examples of existing programs and pilot efforts include Freedom from Hunger's (FFH's) "Credit with Education" program and The People's Bank of Nigeria's (PBN's) "Banking for Health" component. According to WHO, Nigeria "...has pioneered the marriage between credit and health through a national financial institution [PBN] and a project sponsored by WHO on 'Promoting Health through Female Functional Literacy and Intersectoral Action'..." (World Health Organization, p.8).⁴ WHO representatives also cite other integrated enterprise credit and health schemes that are currently being initiated in Burkina Faso (FAARF, The Support Fund for Gainful Activities by Women), Egypt (Social Fund for Development), and Zambia (Ministry of Community Development and Social Services).⁵

The most overriding issue associated with these programs is their cost. The provision of health education and screening associated with minimalist credit programs significantly increases overhead (such as personnel) costs. Preliminary data from several pilot efforts of this type show a range of costs. For example, FFH/Thailand and CARE/Guatemala spent approximately US\$231 and US\$133 per beneficiary in 1990, while nonpilot village banks such as the Foundation for International Community Assistance (FINCA)/Northern Mexico spent only US\$48 per client (Holt, in Otero and Rhyne, p. 169).⁶

To date, it is unclear whether the additional costs can be fully and effectively incorporated into overall program cost recovery. Though Freedom from Hunger, for example, has more than five years' experience with credit and education programs and predicts that country operations will become self-financing within five to six years, its programs in Thailand, Ghana, and Burkina Faso still require external financing and guarantees. The question of project financial sustainability and replicability also remains an issue for credit/health programs. At the "Banking for Health" workshop, WHO promoted the continued pursuit of these models, though all of the programs cited have outside donors funding the health components. One should also note that credit/health education programs should be implemented in

⁴See Annexes C and D for program descriptions.

⁵See Annexes E and F for more information on the proposed criteria and emerging model for "Banking for Health."

⁶Pilot projects will incur higher costs. Costs of FINCA/Northern Mexico appear to be unrealistically low because the project manager uses his own car and computer. However, educational components do increase administrative costs. Problems of transparency arise because many village banks do not sufficiently break down cost reporting to determine whether additional costs resulted from educational services or higher costs for financial services (Holt, 1991, p. 51).

conjunction with financial mechanisms, such as PBN health loans, which can serve as a safety net during the interim period when people begin to change their health practices.

Issues for Microfinance Institutions

The new health care finance concepts mentioned above are timely, as experts are beginning to agree about the need for separate institutional mechanisms for the finance and delivery of health care services. According to research conducted under USAID's HFS project, "...it is generally accepted that direct service delivery (by the same insurer/provider) ...fosters low quality of care, inefficient service delivery, moral hazard, and ultimately high costs"⁷ (LaForgia and Griffin, p.184). Programs such as Freedom from Hunger advocate the use of partner organizations (such as local NGOs, credit unions, or banks) for effective implementation of health care financing. The issue is how best to integrate finance and delivery systems without sacrificing distinct health care and business expertise.

In addition to identifying the appropriate role of microfinance in health care delivery, today's health care programs face other issues that would need to be considered before collaboration with microfinance institutions could take place. LaForgia identified two key research issues in the case of the Dominican Republic. First is the question of whether health programs should be voluntary or mandatory for microenterprise loan clients. Lessons learned in HFS projects in Zaire and the Dominican Republic and Service Expansion and Technical Support (SEATS) family planning projects worldwide indicate that having a sufficiently large pool of beneficiaries has been a key factor in cost control and project success (LaForgia and Griffin, pp. 29, 186; Fort, 1994, p. 3).⁸ The question of potential volume of participants is critical in the planning of such projects, in order to recover costs and avoid adverse selection.⁹

The second issue to consider before microfinance and health program collaboration can take place, according to LaForgia, is the question of ownership and financial risk-sharing. In the case of the Dominican Republic, it was suggested that the health care provider assume the risk of service delivery while the lending associations assume the risk of fee collection. Additional financial and administrative risks and responsibilities will be key considerations in determining whether microfinance institutions are willing or able to expand the type of credit and savings services needed to finance health care.

More research would need to be done to determine whether microfinance institutions are ready to expand their services. This would also need to be considered in the context of overall microenterprise programming goals and objectives, comparing the market for health-related financial services with that for other potential financial products, such as shelter lending. Regardless of the type of new financial products offered, the continued development of savings services and flexible financial services, including credit, are key in the process of further developing the state of the art in microfinance.

⁷Moral hazard is market failure due to "...the tendency of consumers to use more of a service when its marginal cost...decreases." Reducing the financial cost of disease may actually lead to people taking less care of their health, resulting in more illness and demand for care (World Bank, p. 56).

⁸See Annex G for other key success factors.

⁹Adverse selection is market failure resulting from a disproportionate number of high-risk individuals participating in and utilizing health care services (World Bank, p. 56).

Social Marketing and Education to Create Demand

Other potential methods that have offered a degree of success in the "creation" of demand in developing countries involve social marketing and/or education to promote health care programs, products, and consumer advocacy. Examples include successes with increased awareness of and market demand for oral rehydration solution. Family planning project experience indicates that the use of an existing commercial infrastructure for social marketing will increase program efficiency and prospects for sustainability (Logan, et al., p. 7).

Social marketing and education issues to consider include the costs associated with social marketing, health care providers' ability to meet demand once people are aware of services, and clients' ability to pay for services. Previous USAID experience with social marketing could provide a starting point for evaluation. Many programs, such as the Lesotho Urban Sanitation Improvement Scheme (pit latrines), have offered credit and promotion/education programs but have not charged borrowers for the full cost of services (Dhillon and Philip, 1994, p. 99; Varley, 1995, p. 40). Cost issues are particularly significant because, according to development professionals, health care recipients have been unwilling to pay for preventive or education-related health services (Olson). Microenterprise experience with literacy and other nonfinancial services shows similar trends. As a result, social marketing for microenterprise may require creative pricing or be most viable when considered within the context of microenterprise credit.

DEVELOPING SUPPLY-SIDE INTERVENTIONS

Supply-side interventions to expand the health sector can take the following forms: institutional development to enhance the operations of existing health care providers, subsector business development to create new enterprises, or infrastructure and input support for the industry. The following sections examine the issues and state-of-the-art experience in developing the supply of health services.

Institutional Development

Microenterprise and health care programs can be enhanced through supply-side interventions to strengthen the institutional capacity of health care providers delivering services. On the one hand, microenterprise development programs and lenders could become part of the health care financing and administrative system, as was mentioned in the previous section. Alternatively, microenterprise development methodologies could provide institutional support to enhance the private sector profit orientation and client orientation of existing health care delivery systems. In order to achieve these goals, two key issues must be addressed — the need for a skills mix in business and health care, and cost recovery/containment.

Need for a Skills Mix in Business and Health

Microenterprise and health care experts agree that business management and health care expertise are distinctly different and important to the success of private sector health care providers. Though the health sector acknowledges a great need for advanced business training and skills, USAID, with its Private Initiatives for Primary Healthcare (INITIATIVES) Project, has only recently begun to develop methodologies of how to best integrate or cross-train for the two skills sets.

In the enterprise development field, some progress has been made in the identification of key institutional capabilities and characteristics. The SEEP Network, representing 45 private development organizations, has developed a framework outlining the key success factors and “stages of development” for institutions implementing small enterprise projects (Otero and Rhyne, pp. 76-78).¹⁰ Examples of key issues associated with enterprise programs include an understanding of people as clients, rather than beneficiaries, and “...the special challenge organizations face when they try to incorporate small enterprise development into a previously established mission (particularly if it is social-oriented)” (Op. cit., pp. 79, 83).

A number of program interventions exist that could potentially enhance the mix of business and health skills among existing health care providers. One is adapting management and marketing training programs from the microenterprise field. For example, the (INITIATIVES) Project will be producing a series of manuals for health care professionals to improve their business skills. Expertise and lessons learned in microenterprise lending could be applied to the development of fee collection or credit mechanisms for health care services. Of importance in the health care sector are the following: information systems for both health care and expense reporting, wage and pricing structures to minimize corruption and encourage efficiency, billing systems to meet both provider and consumer needs, and management structures including both technical and administrative support.

Such adaptation of training and technical assistance is important to ensure that management and systems are sector specific to maximize service efficiency and effectiveness. Past collaboration between enterprise and health experts has included the involvement of business schools and credit experts in training, and groups such as the Grameen Bank as informal collaborators. Direct collaboration between enterprise and health programs could provide even more beneficial and systematic support and should be based upon health program administrative needs.

Cost Recovery/Containment

The key measure of future success for private sector health care providers will be their ability to control and recover costs. This can only be achieved when organizations reach a sufficient scale of operations. Both family planning and health care project experience indicate that a large client base and an integrated product mix of more and less profitable activities increase the likelihood of financial sustainability (LaForgia and Griffin, p. 18; Fort, pp. 2-3). Of particular interest are the major expenditures in health budgets — personnel (40 to 90 percent) and pharmaceutical (20 to 30 percent) (Bossert, 1994, p. 17).

Policies and procedures to administer and collect fees for health care services should be based upon legal standards and what is appropriate for the financial needs and interests of clients. Cost recovery systems based solely upon drug sales or fee-for-service delivery will lead to overprescription and inappropriate use of services (McPake, et al., 1993, p. 1,389; World Bank, p. 56; LaForgia and Griffin, p. 155). Issues of adverse selection and moral hazard, as well as other potential market distortions, also should be considered when developing cost systems and financial projections for health care.

¹⁰See Annex H for the detailed framework.

Subsector Business Development

Another supply-side approach for collaborative interventions across the health care and microenterprise sectors would be the development and/or financing of microenterprises in the health sector. Unmet needs for health care services and recent market liberalization could offer new microenterprise development opportunities. Market information gained through health programming could be analyzed using the microenterprise subsector methodology, in order to identify interventions with the most promise.¹¹ Subsector development in health care will increase income generation and participation in health care programs, thereby enhancing overall market demand and growth.

Incentives for Business Creation

Although enterprise development opportunities in health care are increasing, to date there is little experience in or methodological basis for evaluating and systematically pursuing such activities. Microenterprise programs have had minimal experience with health-related businesses.¹² Because experience has shown that microentrepreneurs are typically risk-averse, and that creating new businesses tends to involve many business failures, how to best create incentives for entrance into the health market will have to be explored in more detail.

Lending to Health Care Providers and Identifying Viable Opportunities

In the past, health care projects have provided small loans and business training to groups such as doctors, midwives' associations, and traditional healers. Currently, a pilot effort directly linking microenterprise and health care programming is being implemented as a component of USAID's HFS project. Additionally, the INITIATIVES project, based on the Prosalud model in Bolivia¹³, was designed to test the extent to which the private sector (specifically, doctors and midwives) can provide financially sustainable basic health care services to low-income populations in urban and peri-urban areas. The idea behind the project is to identify and develop — with limited technical assistance and financing — cooperative health care delivery mechanisms that can achieve economies of scale. In Ecuador, FEE (Fundacion Eugenio Espejo), one of the INITIATIVES collaborating health care providers, is currently exploring linkages with microenterprise groups (*INITIATIVES Annual Report*, 1994, p. 11).

In addition to the INITIATIVES project, USAID's Center for Population, Health, and Nutrition (USAID/PHN) has developed the Promoting Financial Investments and Transfers (PROFIT) Project, which

¹¹See Annex I for a description of the subsector approach.

¹²Health professionals such as doctors, midwives, dentists, and nurses have fallen outside the definition of "microenterprises" despite operating as proprietors with fewer than 10 employees. This is because of the general exclusion of "professionals" in the definition of microenterprises. The rationale typically given for this exclusion is the formality of these enterprises, the skill level of their entrepreneurs, or the capital requirements of such businesses, which typically exceed those needed in the rest of the self-employed sector.

¹³Prosalud was started 10 years ago through a private sector initiative to provide health care services superior to those available from inefficient public sector systems. It is highly regarded in the health finance field. Key success factors have included an incremental methodology starting with primary health care and user fees, and sound program management.

merits attention. PROFIT is designed to enhance private sector participation in family planning activities through assistance with manufacturing, marketing, or distribution, as well as through investment support to link providers with large employers or insurance companies. Although many of the activities may take place on a medium-size or large enterprise scale, PROFIT has also developed a US\$1 million loan fund for midwives through Bank Rakyat Indonesia (BRI), as well as loans of US\$2,000 to US\$7,000 to doctors starting private practice in the Philippines.

Another area of cross-cutting business subsector interest includes the development and provision of water supply and sanitation service in association with shelter improvements. In a recent USAID Environmental Health Project report, Robert Varley advocates the use of microfinance institutions as an important part of the financing strategy for urban and peri-urban water supply and sanitation.¹⁴ In fact, some of the more successful and well-known microfinance institutions have already begun to expand their services in these areas. For example, Varley notes, "the Grameen Bank offers home-improvement loans to long-term clients in its best performing groups, although this program is peripheral to its main mission of providing banking services — microenterprise credit and savings facilities" (Varley, pp. 47-48). In India and South Africa, members of the Self-employed Women's Association (SEWA) and the Self-employed Women's Union (modeled after SEWA) are demanding and using small loans for shelter improvements. Project experiences, data, and methodologies from USAID/PHN and USAID's Environment and Urban programs should prove to be very useful in assessing health-related microenterprise development opportunities. More study would likely need to take place to identify which sectors and geographic locations offer the most potential market opportunities.

Market Environment across Regions

An "enabling environment" is key to the success of microenterprise/health delivery efforts and depends upon the overall legal/regulatory environment, market structure and prices, and the ability of providers to meet consumer needs and demand. In their 1993 evaluation of the Bamako initiative for primary health care, McPake et al. identified four key enabling issues, which are described below (McPake, et al., p. 1,383).

First, the success of health care services and enterprises depends on the level of decentralization of the host government. Because health care has traditionally been a highly centralized and regulated activity, private sector delivery systems can only be established in environments providing the necessary policy support to allow efficient and profitable operation. Though government regulation is necessary to ensure consumer access to services and quality standards of safety, overall legal and regulatory systems should encourage the private sector's involvement.

Second, past traditions of "free" or subsidized health care services may indicate limited market liberalization or a potential government bias against profit-based health care delivery. Distorted consumer expectations in the marketplace may also diminish the profit potential of new private sector enterprises. If such ingrained market perceptions by either government or consumers exist, the likely success of private sector interventions is low.

Third, consumer perceptions regarding quality have often been influenced by government clinics and hospitals, with severe supply shortages prevailing and limited numbers of private enterprises offering

¹⁴USAID Bureau for Global Programs, Field Support and Research, Office of Health and Nutrition.

services at near monopoly prices. In order to successfully compete in these markets and achieve consumer confidence, these perceptions must be overcome.

Finally, competition from alternative subsidized providers (for example, other donors) may limit the success of new health care delivery systems. An understanding of existing health care finance and delivery mechanisms and cooperation among donors and host governments, where services are duplicated, are necessary to achieve project success.

General economic conditions can also dramatically affect health care programs. For example, in the self-financing health program in Odessa, Ukraine, cost control has been a significant issue because of runaway inflation (Raney and Makinen, 1994, pp. 8-11). The HFS and Data for Decision-Making projects, through the USAID/AFR (Africa Bureau)/SD (Sustainable Development)/Health and Human Resource Analysis for Africa (HHRAA) Project, have recently completed four African country surveys of independent health care providers concerning types of operations and private sector constraints faced. In Tanzania, for example, health care market liberalization has created numerous enterprise opportunities, and limitations to microenterprise were reported to be financial constraints. Additional surveys of this type, more specifically tailored toward market assessment, could prove useful in the development of health subsector opportunities.

Because market conditions and health care policy environments differ dramatically across developing countries, so must program interventions differ in complexity and structure. For example, according to USAID health program experts and contractors, difficulties in Latin American health programs include barriers set up by entrenched government bureaucracies. In Africa, health programs work at a much more basic level, and preliminary dialogues for policy reform are being established. Asian health care programs are often more advanced, with USAID providing technical assistance for private sector delivery systems. In the New Independent States, market reform is given priority in order to identify and develop private sector health care delivery.

Infrastructure and Inputs

In addition to the market environment, a country's level of infrastructure and support systems, technology, and number of trained physicians will dramatically influence health care subsector business development. Potential markets for project intervention must first be evaluated for such factors in the macroenvironment. Though limits to infrastructure and health care inputs (such as drugs) can pose formidable obstacles, these limits can also be seen as opportunities for donor funds to improve significantly the quality of services and information systems available.

Quality

Quality of services is consistently identified as a key market factor for health care. HFS project experiences in Zaire, Costa Rica, and China indicate that perceptions of poor quality and availability of supplies had an adverse effect on client utilization of health care services (LaForgia and Griffin), while quality improvements in Zaire were shown to increase client volume. Donor support to subsector business development, therefore, could include technical training, market assistance to access inputs, or policy reform to support business development. Although these types of interventions would not all directly utilize the full expertise of microenterprise experts, subsector analyses may indicate a need for such

interventions. Market studies can also help health programs and entrepreneurs, such as doctors, pharmacists, and midwives, and identify client needs for health care products and services.

Information Systems for Health and Finance

Subsector business development in the health care field can also significantly benefit from project support to develop management information systems (MIS systems) for health and financial data. Particularly as institutions (such as many of those in the New Independent States) grow in size and scope, information systems provide key improvements to operational efficiency and cost recovery. Information systems are important at all levels of health care delivery and administration and can significantly aid in tracking efficiency and cost control.

In a January 1995 presentation on urban health and the environment, Diana Silimperi of USAID's BASICS project recommended the development of urban health care MIS systems for local decision making and planning, in order to foster consumer demand and the ability of health care institutions to respond to demand (Silimperi, 1995).¹⁵ In a 1994 analysis of the Self-Financing Program at the International Medical Research Family Health Center in the Ukraine, Raney and Makinen recommended MIS improvements as essential to improving the collection and accounting of fees, tracking costs and pricing, and monitoring patient records and demographics (Raney and Makinen, pp. 26-28).

ROLE OF SUBSIDIES AND DONORS

Existing Subsidies

Health Sector

Based upon public sector origins and financing, subsidies and public sector involvement in private health care provision in developing countries are long-standing and extensive. According to Catherine Fort in her follow-up study on the USAID Enterprise Program, "The issue of providing long-term subsidies (both in-kind and monetary) to private sector partners is complex; it is also tied to larger public policy issues concerning the availability of affordable services." Government ministries of health continue to provide subsidies, as do outside donors, NGOs, private voluntary organizations (PVOs), and other voluntary organizations. According to Fort, public and private sector partnerships that share family planning costs "currently seem to be the norm." Thus, there is often no clear distinction between purely "public" or "private" services.

In order to stimulate private sector development, health programs have restructured existing subsidies to better support market incentives. "Incentive payments or the provision of free supplies may be used to encourage private providers to offer preventative services," say Bennett, et al. (1994, p. 8). One example involves child immunization programs, which are initially subsidized and later charge fees.

¹⁵BASICS is a USAID-Finance project administered by The Partnership for Child Health Care, Inc.; the Academy for Educational Development; John Snow, Inc.; and Management Sciences for Health.

Because there are numerous subsidies for health care supplies (such as vaccines and drugs), microenterprise programs could link with providers of subsidized goods. One advantage of such an arrangement would be increased reliability of quality and supply. Indeed, in the USAID Enterprise Program, family planning subprojects with the best likelihood of financial viability were found to use subsidized goods and services available in the marketplace (Fort, p.2). (See Annex G for a summary of key success factors in the Enterprise Program.)

Subsidies have a disadvantage, however; namely, they distort market factors and the potential profitability of private health care services. According to Fort, the Enterprise Program identified subsidy-based price distortions as a major impediment to the development of private sector family planning enterprises. Therefore, the identification of subsidies and collaboration and communication with the host government and other donors are crucial. Fort also suggests that additional attention and research be directed toward consumer market behavior and enterprises' ability to make a profit in a distorted marketplace.

Microenterprise Sector

Subsidies also continue to be a part of many microenterprise lending programs, though significant progress has been made regarding cost recovery and the management of funds. In *The New World of Microenterprise Finance*, Otero and Rhyne describe the following four levels of self-sufficiency for microenterprise lenders:

- Level 1 — Level 1 programs are traditional, highly subsidized programs in which, for example, soft loans are used to cover expenses and capitalize a revolving loan fund.
- Level 2 — Some subsidy still is required at this level, but the lender charges borrowers near market interest rates to cover the cost of funds and part of operating expenses.
- Level 3 — At this level, most subsidies are eliminated, but some form of subsidy remains. (Level 3 applies to most well-known credit programs, such as Grameen Bank.)
- Level 4 — Level 4 programs are fully financed from client savings, and funds are raised through formal financial institutions at commercial interest rates; real costs are covered. Examples include certain credit unions and the BRI Unit Desa system in Indonesia.

Microenterprise lending methodologies and structures have achieved a significant degree of outreach, financial sustainability, and subsidy reduction. However, the process remains ongoing. Debate continues regarding the extent to which training components of lending programs can become self-financing. Several ACCION international affiliates, however, show that full cost recovery of training services can be achieved through fees to borrowers (Otero and Rhyne, p. 138). This trend should be the next step toward sustainability and full cost recovery for financial and nonfinancial services, including health care or education components.

Because the state of the art in financial services is still striving toward level 4 and health care services are often a public/private blend, the complete or immediate elimination of subsidies is unlikely. However, funding constraints and rising health costs necessitate the reduction of subsidies by host governments and donors. The challenge is to continue to develop more diversified financial products and

nonfinancial services to meet client needs, and to support the private sector to expand the health care market.

Coordination among Donors

The importance of communication and coordination among donors in the health care sector cannot be overemphasized. The parties involved range from the host government ministry of health to bilateral donors (such as the World Bank) to NGOs and local private voluntary groups providing child-survival or other health care services. This section will examine some of the key players, their current roles, and how USAID may consider providing collaboration or assistance in enterprise development support.

Ministry of Health

Because of its position of leadership in national health programs, a government's ministry of health (MOH) is of primary concern to potential microenterprise/health project activities. On the broader side of health reform, the development of the private sector can allow an MOH to better streamline its activities to become more efficient and cost-effective, as the World Bank has suggested in its identification of the basic "package" of public health services. Related infrastructure development initiated by the private sector, such as the development of information systems, can also improve and support growth in the health care industry as a whole — in both the public and private sectors. USAID has the opportunity to use the influence of previous health programs and contacts to change policy to promote and allow for greater private sector development.

NGOs/Local NGOs

Other key players that provide significant levels of health care services in developing countries include international PVOs and local NGOs. The World Bank estimates that NGOs provide one-third or more of all clinical care in the following countries: Cameroon, Ghana, Malawi, Uganda, and Zambia (World Bank, p. 127). Because of their size and presence, as well as the comparatively positive image regarding their quality of services, NGOs will remain influential partners for donors such as USAID.

USAID should improve its monitoring and evaluation of NGO credit and health programs to measure more closely project impact and cost recovery. Because of the importance of a solid blend of business and health expertise, the NGO community and USAID health project staff are prime candidates for additional training based upon the GEMINI experience. In turn, NGOs such as Freedom from Hunger can then better train partner financial institutions. Health professionals at the April 18, 1995, GEMINI expert workshop in Washington, D.C., strongly agreed that business training is an important need and interest in the health community (Olson).

Despite their experience in health and village banking programs, NGOs still struggle to develop replicable and viable financial services. According to Otero and Rhyne, currently no NGOs operate exclusively on funds borrowed from commercial sources. Generally, they add, when NGOs scale up their microenterprise programs, they concentrate almost exclusively on developing lending methodologies and mechanisms. However, more attention must be paid to savings services in order to develop financial institutions to support microenterprise and health care finance. Interventions directed at increasing the

capacity of financial institutions to meet consumer demand for financial services will best serve both sectors.

Limitations to Collaboration

Before examining specific program or research recommendations, one should note the barriers that currently limit collaboration between microenterprise and health programs. In USAID, for example, few incentives exist to develop collaborative programs or funding mechanisms across sectors. The GEMINI project did, however, make some progress toward removing barriers and misconceptions through its “Expert Workshop Series,” in which professionals from USAID’s Office of Microenterprise Development met with representatives from the agency’s Health (Population, Health, and Nutrition), Environment, Housing (Shelter), and Agriculture offices. This dialogue and sharing of lessons learned will be an important step toward the development of state-of-the-art economic growth strategies across sectors.

From a policy standpoint, cross-sectoral benefits are clear and include the joint pursuit of market reforms affecting both the health and microenterprise sectors. From a project standpoint, however, the difference between microenterprise and health project time frames for monitoring and evaluation must be addressed. Specifically, enterprise projects are typically developed within a five-year time horizon, and profitability and economic return are measured accordingly. The social impact of health projects, on the other hand, is more difficult to measure and often has a longer-term program horizon. To develop projects including both microenterprise and health components, these differences would need to be reconciled and distinct financial and health indicators developed. Finally, funding constraints would necessitate increased expectations for measurable project impact, cost-effectiveness, and leveraging of resources. Together, microenterprise and health programs can create the synergy necessary to meet the development needs and expectations of the future.

PRIORITIZING THE OPTIONS

In order to prioritize the programmatic options available to the USAID Office of Microenterprise Development, one should examine a few basic questions. First, the “enabling environment” must be evaluated to determine whether minimum requirements for market liberalization and infrastructure exist to allow for private sector interventions on the demand or supply side. Next, USAID microenterprise development and organizational goals must be clarified. Of particular interest is the level to which the poor can be reached through microenterprise development activities in the health sector.

Assessing the Enabling Environment

Because of the overriding influence of the policy environment and health care infrastructure on the effectiveness of any health care interventions, these factors must be assessed as part of the programming process. At the GEMINI expert workshop this past April, health and microenterprise practitioners suggested the development of a litmus test to evaluate the viability of microenterprise/health interventions in any given country. Specifically, USAID’s family planning project experience in the for-profit sector indicates that the following characteristics are important in country selection:

- A commitment to the program's purpose;
- A secure for-profit sector; and
- The existence of potential service providers.

To scrutinize a country's enabling environment even more closely, the Data for Decision-Making Project, administered by the Harvard University School of Public Health, has identified a set of factors to review the policy environment for the private sector, as well as methods to categorize and survey the number and type of private health care providers in a country (Berman and Hanson, 1994, p. 19). These methodologies were used in national surveys of health care providers in Kenya, Zambia, Senegal, and Tanzania conducted under the Data for Decision-Making Project and the HFS project. The country surveys were particularly significant because they were among the first to interview business persons involved in health-related activities, as opposed to traditional client surveys or ministry of health interviews. As a result, not only might these country data be of use in diagnosing potential microenterprise/health interventions, but the methodologies could be adapted for enterprise development purposes. Building upon this knowledge base and existing market surveys in potential "pilot" country markets, future microenterprise programs could identify and pursue methodologies to gauge whether individual country markets are sufficiently liberalized to allow private sector microenterprise and health interventions.

Reaching the Poor

Health program experts are beginning to agree with what the microenterprise field has proven — the poor can and will pay fees for quality services that benefit them. Nonetheless, although microenterprise programs have helped increase income streams and financial mechanisms for the informal sector, both microenterprise and health program experiences indicate that the transaction costs of reaching the poor remain high, and specifically targeting services for the poor has not worked. The World Bank adds that health care services designed only for the poor "will almost inevitably be low in quality and will not receive the political support necessary for adequate supervision" (World Bank, p. 70). USAID project lessons learned echo this observation, indicating that for-profit health programs cannot "first and foremost address the needs of the poorest members of a country's population"; rather they can "...help institutionalize self-sustaining programs, which can then free resources for areas of highest need" (Logan, et al., p. 7).

Given the above, the best way to extend financial and health care services to the poor would be to continue to develop microfinance institutions and the village banking model to expand their scale of operations, financial efficiency, and ability to borrow funds from commercial lenders. This will require trade-offs in the individualized procedures and technical assistance currently offered. However, say Otero and Rhyne, if village banks and local health clinics "...do not overcome the constraints that are keeping them small, they will be unable to play a significant role in poverty reduction."

Determining What Offers the Most Potential

Given the experience of health and microenterprise professionals and the requirements of providing services to poor people, what interventions and approaches offer the greatest potential?

First, demand-side interventions should be client driven. There is a natural progression of client demand from microenterprise credit to financial services to pay for health care, sanitation, and health emergencies. Demand for health care and health-related enterprise development will continue to increase.

Consequently, the role of the Office of Microenterprise Development should be to improve the outreach and capabilities of microfinance institutions to meet these new client needs through savings services and expanded credit services. Increased flexibility and financial viability of financial services will offer benefits on both the demand and supply sides. Leading microfinance institutions such as the Grameen Bank, SEWA, and ADEMI are already beginning to offer more diversified lending and savings schemes for health emergencies and home improvement and sanitation. Linkages with local health care providers or educators could also be developed according to client interests.

Second, financial services and standards, such as loan limits, must also become increasingly flexible or at least adaptable from region to region. ACCION solidarity group programs, CRS/Senegal, and FINCA/Costa Rica are examples of village banking programs that have abandoned the US\$300 loan limit as being inappropriate for the local context. Liedholm and Mead's review of data on microenterprises indicate that initial capital requirements for small businesses range from US\$49 in Sierra Leone to US\$1,104 in Jamaica (Otero and Rhyne, p. 166).

The need for larger amounts of capital will be particularly evident in the health field, where doctors or midwives may require medical or laboratory equipment as part of their businesses. Such clients, as well as reliable loan clients whose enterprises have grown beyond the "micro" capital or employee level, should not be unduly excluded from financial services that may not be available from other sources.

Finally, project support to develop microfinance institutions should include specific training and financial performance criteria aimed at strengthening the institutional capacity of NGOs and local partner organizations. If these institutions are to develop expanded outreach and more cost-effective and sustainable operations, USAID will need to take a more active role in establishing reporting and evaluation criteria to increase the transparency of their financial performance. The Office of Microenterprise Development can take the lead in expediting and encouraging this process for microfinance lenders of all types and scales.

On the supply side, the Office of Microenterprise Development can, first of all, continue to share lessons learned in the areas of business development, financial services, and market analysis. Health care programs are increasingly incorporating these types of activities into private sector health care projects and could benefit from collaboration or cross-sectoral training. In some ways, the health care field is still at the beginning stages of incorporating a business and "profit" perspective into its programs. Helping health care programmers and professionals to internalize a profit and client orientation are key contributions the microenterprise sector could make. The programming challenge for donors is to encourage and support, not interfere with, the private sector. As a result, health sector interventions should be carefully thought out and strategically based.

Demand for microenterprise loans for health-related business development will expand based upon market opportunities in newly liberalized markets. USAID should continue to support the development of microfinance institutions and their ability to assess the feasibility of health-related business activities and provide financial services.

Microenterprise subsector opportunities of particular interest include health professionals (doctors/nurses/midwives) offering private services, and urban sanitation and waste management services. Health projects, such as PROFIT and INITIATIVES, are financing some of these types of activities, and microfinance institutions should consider health professionals as potential new clients, even if their capital requirements are more than the US\$300 level used by some village banks. The USAID Office of Environment and Urban Programs is currently developing programs, such as "Healthy Cities," that could

include microenterprise expertise to develop private sector waste management services. GEMINI subsector methodologies could help identify specific market constraints and opportunities involved. Microenterprise involvement with health programs should also utilize the health program experience on the supply side, in order to develop economically viable enterprises and financial services.

Exploring Research Questions

The following research questions are of particular relevance to the expansion of the microenterprise and health sectors:

- How can microfinance institutions scale up their savings services? What criteria should be used to determine whether these institutions are ready to expand credit and savings services beyond microenterprise? What indicators can be used to measure this process?
- How can NGOs increase the transparency of their cost reporting and financial services management in order to increase cost recovery, scale, and sustainability?
- Is it possible to cover the cost of nonfinancial (including health) services as part of microenterprise savings and credit systems? Is the “Banking for Health” methodology worth pursuing? Should educational or health-related services for microentrepreneurs be subsidized?
- Can microenterprise credit groups be clients for health care program interventions without sacrificing the integrity of financial services and repayment rates? What benefits can be measured from collaborating with health care programs? Can pilot efforts between microenterprise and health care programs (such as HFS, INITIATIVES, PROFIT, and Environmental Health) further the state of the art in microfinance?
- What are the scale and exact nature of the impact of health/disease on microenterprises and microenterprise credit repayment? What is the role of women in this process?

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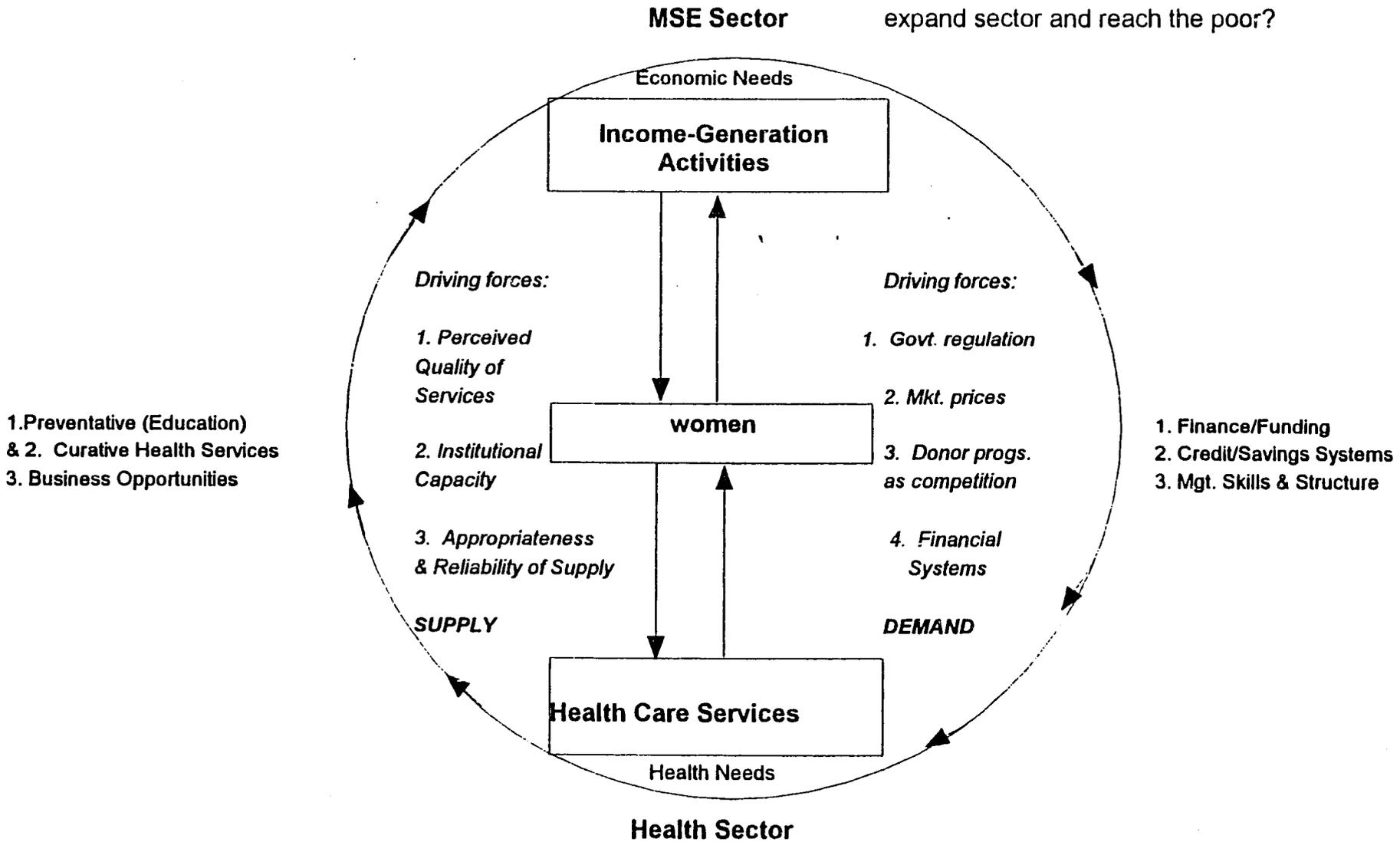
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ANNEX A
SUMMARY DIAGRAM OF MICROENTERPRISE
AND HEALTH SECTORS

Question: Microenterprise as financing &/or delivery mechanism for preventative and curative health care services to expand sector and reach the poor?



ANNEX B

**PROGRAM MODEL LINKING MICROENTERPRISE LENDERS AND
QUALIFIED HEALTH PROVIDERS, DOMINICAN REPUBLIC**

EXECUTIVE SUMMARY

This report explores the potential for extending health care services to low-income families residing in Santo Domingo through prepaid HMO-type health plans known as Iguales Medicas. Iguales are private firms that combine the financing and service delivery aspects of health care. Lending associations that provide loans to informal sector microenterprises are another major focus. Through an analysis of Iguana and lending associations' operations, this report seeks to explain the financial and administrative arrangements whereby the Iguales can be matched with a large yet specific segment of the informal work force, microenterprise entrepreneurs and employees. Currently, these groups receive what is widely regarded as inadequate health care at state health facilities or pay out-of-pocket for private care.

The Iguales are not insurance institutions in a strict sense. That is, they are not mechanisms that focus solely on protecting the individual against catastrophic financial loss due to an illness- or injury-causing event. Similar to U.S.-based HMOs, the Iguales integrate the insurance and provider functions. They are prepayment systems that cover a specified volume and range of services. In exchange for a predetermined monthly premium, the Iguales offer their members a fixed package of outpatient and inpatient medical services.

Eight of the largest of a total of 20 Iguales operating in Santo Domingo were sampled in June 1990. Taken together, the samples represent approximately 75 percent of the Iguana-insured population in Santo Domingo. Most Iguales are physician owned and operated. Many are affiliated with a single hospital and a specific group practice. Others are linked to a broad network of facilities and providers.

Iguales have existed for more than 20 years in the Dominican Republic. Although concentrated in Santo Domingo, the Iguales also provide coverage in other urban areas. In general, the Iguales are successful business enterprises because they have captured a large segment of the middle- and working-class population through employer-based group plans. They have been particularly successful in selling their product to small and middle-size companies. This report surveys a cross section of benefit packages designed for low-income employees.

In comparison to indemnity insurance plans, the Iguales offer a similar or superior benefit package for a lower premium. Unlike indemnity insurance, however, Iguana enrollees are required to utilize a restricted number of facilities and physicians. However, the Iguales' success in the marketplace shows that they fulfill an important need that consumers are unable to meet through the public sector, social security, indemnity insurance companies, or fee-for-service private providers.

Further, unlike the client orientation of traditional insurance companies that shape benefits to the needs of the individual or group, the Iguales appear to be primarily oriented to the income needs of their physician owners and associates. Most Iguales were founded by a group of physicians as a means to channel a greater volume of patients to their private practices. Risk exposure is limited with co-payments, steep discounts from providers, and coverage restrictions. Because of the physician orientation of most Iguales, cost containment is still in a development stage. Many Iguana executives are eager to learn more about managed care and cost containment practices in the United States.

Two lending associations that provide loans to informal sector microenterprises were studied. These organizations are interested in providing health coverage to their members through the creation of a risk pool consisting of microenterprise owners, employees, and dependents. Executives from both organizations have offered their network of field "promoters" as a means to market a plan and to collect

premiums. Some executives suggest that premiums should be incorporated into the loan principals to facilitate collection. Iguana representatives have also expressed interest in bidding for all or part of the potential microenterprise risk pool. Because of the excess capacity of their provider networks, many Igualas seek greater volume.

This report concludes that USAID has an opportunity to facilitate a match between lending associations and the Igualas Medicas to provide health coverage to a potential population of 100,000 people in Santo Domingo. It is recommended that USAID facilitate the creation of the lending-association-based risk pool and assist the Igualas in setting up the provider network and in designing the appropriate (and affordable) benefit package. Three extension models are suggested. A pilot project is proposed whereby at least two of the models are tested on a demonstration basis.

Two issues will need further study before coverage is extended. The first involves the question of adverse selection. That is, if the scheme is voluntary, those who are the most ill will be the most likely to enroll. A survey of potential enrollees will be needed to determine demographic and socioeconomic characteristics together with the distribution of illness and utilization patterns. The data will be compared with similar characteristics of the actual enrollees to determine selection bias. Such a survey can also provide a better understanding of the potential market for Igualas services by estimating future subscribers' current expenditure and use patterns and comparing these with what would be feasible under Iguana coverage. In order to avoid having the plan enroll a large proportion of ill members, membership may need to be compulsory for all owners and employees of microbusinesses affiliated with a lending association.

A second issue involves risk-sharing arrangements between the Igualas and the lending associations. It is suggested that the lending associations assume the risk of premium collection while the Igualas assume the risk of service delivery to the members.

ANNEX C

**DESCRIPTION OF FREEDOM FROM HUNGER'S
CREDIT WITH EDUCATION PROGRAM**

Organizational Vision

Freedom from Hunger envisions the creation of a network of partner organizations to facilitate learning, technical assistance, and training for implementing the *Credit with Education* strategy. Freedom from Hunger identifies local NGO or financial institution affiliates to become partners in the implementation of this tightly integrated dual sector strategy in all countries where it operates.

Credit with Education uses credit associations as the grassroots organizational structure for providing financial and educational services to the poor. Each program seeks to cover all recurring costs for the implementing agency, and, to the extent possible, the costs of technical assistance and training provided by Freedom from Hunger within each country.

Operational Approach

Funding. Funding for Freedom from Hunger programs is provided through grants for operational costs not recovered through interest and fee earnings on loans. In four of its programs, Freedom from Hunger partners finance the credit funds either with their own resources (rural banks and credit unions), or through accessing credit from formal banking institutions. Two other programs receive grant funding for credit; however, efforts are being made to obtain loans from local commercial banks.

Technical Assistance and Training. Freedom from Hunger provides technical assistance to partners in the design, implementation, and evaluation of *Credit with Education* programs. This includes developing, testing, and refining the village banking methodology to achieve large-scale, cost-effective, and sustainable programs. Freedom from Hunger also works with partners to develop training systems and materials, administrative and financial systems, and systems for monitoring and evaluation.

Freedom from Hunger staff directly train key management staff in partner institutions to integrate *Credit with Education* into their operations. Partners are also provided with methods, techniques, and materials to train large "classes" of field agents to implement the program. Training includes guided participation in design, implementation, and analysis of baseline studies of credit/microenterprise, nutrition/health, and family planning practices. It also includes training in program marketing, credit association management, and educational techniques as well as technical knowledge about health, nutrition, family planning, and microenterprise topics.

Some of the tools and materials Freedom from Hunger has developed for program implementation are a "Technical Update Series" on key issues for *Credit with Education* implementation; an administrative handbook, including financial and program planning, monitoring, and reporting guidelines; a series of lesson plans for the educational component; and a field agent operations manual for field agents implementing *Credit with Education*.

Freedom from Hunger has a well-developed standardized package of management information systems (MIS systems) that partners integrate into their operational systems. It addresses management of operating and credit funds, credit association accounting systems, and regular credit association performance assessments and program progress reports. Freedom from Hunger is assisting its partners to establish computerized MIS systems where appropriate.

ANNEX D

DESCRIPTION OF THE PEOPLE'S BANK OF NIGERIA CREDIT PROGRAM

Established in 1989, The People's Bank of Nigeria (PBN) is a development bank that provides credit and organizational help to the near-landless poor, who are otherwise excluded from the formal credit system because they lack material collateral and because they cannot afford the high transaction costs of formal financial institutions. PBN has replaced the requirements of material collateral with group responsibility and peer pressure. PBN also provides loans to individuals and social development inputs to the poor so as to make them individually and socially accountable. The bank's loan recovery rate has been consistently over 90 percent, one of the highest among development financial intermediaries (DFIs) providing urban/rural credit. Savings mobilization is also an integral part of PBN's lending. Each member is required to save regularly in a number of accounts such as group funds and emergency funds.

In 1993 PBN covered almost half of the villages in Nigeria, serving about 6 million members and lending about \$12 million, \$1.3 million of which was spent on a scheme linked to primary health care education, and mobilizing \$7 million as savings and deposits. Over the 1989-1992 period, the average growth rates were 29 percent for member mobilization, 38 percent for loan disbursement, and 40 percent for savings mobilization. This shows a faster rate of growth in savings mobilization than loan disbursement.

Loan disbursement from PBN's branches includes general loans to individual members (these loans form the bulk of the bank's loans and are repayable in one year) and the collective loans given to groups or a center for joint enterprises. In response to borrower demand, PBN over time has diversified its lending into other categories, such as emergency deposit schemes, small-scale group enterprises, transport loan schemes, and loans for health.

Over the last four years, the rapid expansion of the People's Bank has been synonymous with the leadership of its Managing Director, Maria Sokenu. However, PBN's phenomenal expansion and high repayment performance have been based also on the evolution of a decentralized management structure. The organization, with its emphasis on learning and adaptability, is staffed by motivated workers who are trained extensively in PBN's underlying norms and administrative processes and are compensated with a competitive incentive scheme. Such a cohesive structure with flexible decision making and well-trained employees has made it possible for PBN to expand its operations rapidly in fewer than three years.

The money received by PBN from the Nigerian Government for various central activities at the head office level influences its profitability and financial viability. As of June 30, 1993, the bank posted a profit of \$300,000. In its initial projection, PBN had forecast a break-even point of 10 years. This was achieved within three years of its operations. PBN branches operate as profit-maximizing units, with funds for on-lending provided by the head office at the market rate of interest.

Because PBN's head office determines both the on-lending and borrowing rates for branches, the branches' profitability largely depends on financial margin (defined as the difference between interest revenue and the interest cost as a percentage of assets). However, econometric analysis suggests that the training of staff and members positively affects branch profit, as does the presence of technology loans in the branch's lending portfolio. Among influential local characteristics, the presence of roads increases the profit of a branch, while the presence of other commercial banks decreases it.

PBN's cost-effectiveness is estimated through the cost-efficiency criterion and break-even rates of interest. For the bank's 271 branches, the break-even rate was around 13 percent in 1990, and increased to 21 percent in 1991 to reach its target for 1993 nationwide. The profit gained between the lending rate and the break-even rate explains the success in meeting the target. The higher costs at the branch level for training, research, development, monitoring, evaluation, and institutional development at all levels are

borne by PBN's head office; however the presence of subsidy (of an average of 7.5 percent of the loan disbursement per year) implies that, given the present cost structure and the amount of outstanding loans, PBN must increase its lending rate to 26 percent if it has to borrow at the market rate.

Based on cost function analysis of branch-level data, it has been found that the marginal cost of mobilizing and lending to a member is much lower than the additional revenue generated and that economies of scale are present in PBN's operations. The results suggest that PBN will still break even at the market rate of interest for on-lending funds by expanding its membership and loan disbursements without raising its on-lending rate further.

For PBN members, the per capita savings over three years has tripled. The recorded low dropout rate among members, the high repayment rate, and the increase in savings suggest that benefits accruing to the borrowers are enough to ensure their viability through PBN membership.

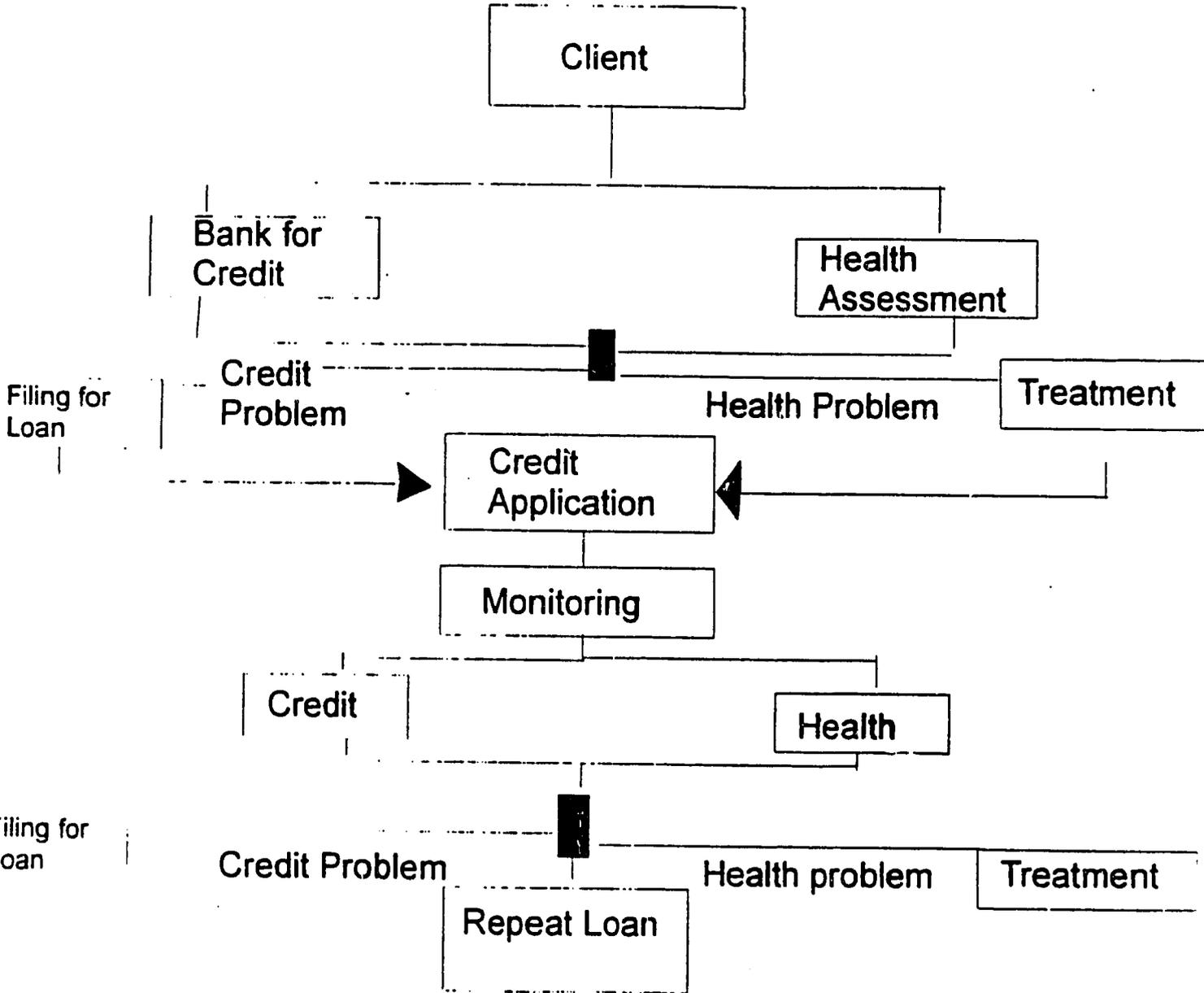
In terms of costs, subsidies are required for other, noncredit services provided to PBN members and for the bank's institutional development. Although the cost-effectiveness of branches underlines PBN's viability as a financial institution for the rural poor, there has been about a 7 percent subsidy (both economic and financial) involved in PBN lending to the poor. If this subsidy is treated as a net transfer to the rural poor, however, each Naira transfer generates a private net worth of Naira 250 as savings in PBN. In addition, the transfer also leads to social gains from improving health, nutrition, and educational outcomes for poor households.

PBN's potential for expansion in Nigeria rests on its ability to remain a sustainable financial institution. Overall, the program has developed the capability to maintain its operations from its own resources without relying on subsidized funds. Given PBN's performance in loan disbursement and savings mobilization in relation to its cost structure, analysis shows that PBN branches have the scope to expand membership and disbursement in order to be profitable. There is ample opportunity for such a credit program, with its objective of poverty alleviation, to expand its coverage in the socioeconomic environment in Nigeria.

Given PBN's success in providing specifically designed credit as a means of poverty alleviation while improving the health status of the poor, the question of its replicability in other countries has become highly relevant. However, the size and modalities of such a group-based organization have to be customized according to the local sociopolitical factors determining the economies of poverty. The criteria for group membership and the types as well as sizes of loans will depend on local conditions, but the disbursement and recovery processes have to be designed for maximum cost-effectiveness.

ANNEX E
PROPOSED MATRIX FOR “BANKING FOR HEALTH”

Proposed Matrix for "Banking for Health"



Source: Ward, Virginia. "Trip Report: Geneva, Switzerland WHO Workshop on 'Banking for Health,'" June 15-17, 1994. Private Initiatives for Primary Healthcare Project, USAID Office of Health, 19 p. 20.

ANNEX F
KEY ELEMENTS FOR CREDIT/HEALTH

KEY ELEMENTS CREDIT/HEALTH

Criteria	Key Element Credit Delivery	Key Elements Health Component
Eligibility	Absence of collateral Willingness to engage in income generating activities	Active participation in community information activities such as functional literacy and vocational training classes
Loan Application Form	Simple, easy to understand	Health and well being assessment as part of the application
Screening	Loans available to groups (group based organization) Loans available to individuals through group or community scheme participation	Identification of principal health risk factors affecting: lifestyle, social environment, physical surroundings Information should be collected both from groups and individuals to be fed into a local health information system collecting data at local level
Loanable amounts	Flexible amounts, easy to repay, with no collateral	Flexible amounts, easy to repay, with no collateral
Interest Rate	Market, or close to market, rates	Market, or close to market, rates
Monitoring and Collection	Standard accounting system for monitoring economic changes Short-term loans weekly collection Decentralized facilities for disbursement and collection (mobile banks)	System for monitoring changes in health
Savings Accounts	Available both for groups and individuals Incentives on interest rate, eligibility for second loan, to encourage savings community shareholding in economic activities	Individual health savings accounts to be used for emergency medical and health needs Group health savings accounts to be used for improvement in community health services, community information activities, funding of community development activities, and hiring community workers, literacy instructors, extension personnel.

ANNEX G

**SUMMARY OF KEY SUCCESS FACTORS FROM THE FAMILY
PLANNING ENTERPRISE PROGRAM**

1. The employment-based programs in the sample that were most likely to be sustained:
 - Had committed company managers;
 - Had family planning programs that were seen by managers as benefitting companies in a tangible way;
 - Had strong linkages with competent sources of technical and logistical support; and
 - Were in reasonably good financial health.

2. Those subprojects that seemed to have the best prospects for achieving financial independence:
 - Integrated low profit-making family planning with more lucrative health services;
 - Had large operating budgets that allowed losses from one program area to be absorbed by savings (or income earned) from another;
 - Were efficient and controlled costs;
 - Set competitive prices for services;
 - Met, or had the potential to meet, the partner's financial objectives; and
 - Took advantage of any subsidized goods or services offered in the family planning marketplace.

3. The most successful and accepted subprojects also had the following:
 - Large company work forces or employee/beneficiary populations;
 - A large number of service points;
 - Umbrella organizations acting as service vendors to a large number of companies under contract; or
 - A large pool of insured beneficiaries.

4. The study also found emerging impediments to private sector family planning sustainability and expansion, many linked to the low profitability of family planning ventures. They included:
 - A longer-than-anticipated time to reach a financial break-even point;
 - Stiff competition for a smaller-than-expected market; and
 - Public sector subsidies on family planning services that kept prices down artificially.

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ANNEX H
INSTITUTIONAL DEVELOPMENT IN THE SMALL ENTERPRISE
SECTOR: A FRAMEWORK

Table 4.1 Institutional Development in the Small Enterprise Sector: A Framework

<i>Components</i>	<i>Stages</i>		
	DEVELOPMENT Start-up, design, testing, and implementation of methodology and structure. Become effective. — Preparation — Start-up — Implementation	SUSTAINABILITY Organizational growth and maturation. Institution advances toward efficiency and financial viability. — Implementation — Consolidation — Growth	EXPANSION Scale-up. Institution expands its program by increasing clients and/or geographic coverage. — Transformation — Expansion
VISION An organization's ability to articulate and generate commitment for its mission. Key factors are executive leadership, board of directors, strategic planning.			
CAPACITY An organization's ability to structure itself; to develop systems and to recruit and train staff. Key factors are organizational structure, information systems, personnel policies, staff development.			
RESOURCES An organization's ability to raise, manage, and account for sufficient revenue to cover expenses. Key factors are fund-raising policies and practices, credit policies, budgeting and financial projections, accounting, portfolio management.			
LINKAGES The ability to develop and maintain productive relationships with relevant organizations. Key factors are government relations, peer networks, international PDO and donor partners.			

H-3

Source: Otero and Rhyne, *The New World of Microenterprise Finance*, West Hartford, CT: Kumarian Press, 1994, p. 78.

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ANNEX I
A SUBSECTOR APPROACH TO SMALL ENTERPRISE
PROMOTION AND RESEARCH

A SUBSECTOR APPROACH TO SMALL ENTERPRISE PROMOTION AND RESEARCH

GEMINI Working Paper No. 10

James J. Boomgard
Stephen P. Davies
Steven J. Haggblade
Donald C. Mead
January 1991

The subsector approach aims to provide operational direction for small enterprise promotion. Other approaches have tended to be descriptive rather than diagnostic. The subsector approach is both diagnostic and prescriptive. It places considerable weight on understanding the interactions — both competitive and complementary — among firms of different sizes and with different functions, within a subsector, including those involved in manufacturing, commerce, and services. Moreover, this approach acknowledges the potential value of indirect interventions, those that route micro- and small-scale enterprise assistance via intermediaries to gain leveraged opportunities to maximize the impact of the intervention.

Subsector research views small enterprises as interacting with other firms — both large and small — in vertical production and distribution systems. By examining the competitive position of firms in alternative supply channels, subsector research aims to understand the dynamic forces at work. The dynamics, in turn, often prove key to identifying growth opportunities and constraints, and hence the potential for policy or project interventions.

Subsector research revolves around four principal concepts: verticality, coordination within channels, competition between channels, and leverage. Verticality is central. Small enterprises are participants in vertical production and distribution systems. They procure inputs from a variety of suppliers and market their output through other firms. Small enterprises face competition from both large and small firms, which are vertically integrated to differing degrees and use diverse technologies. Because of these relationships, coordination with firms performing related functions is central to small-firm dynamics, as is competition with alternative supply channels.

Leverage, crucial to cost-effective intervention, is highlighted by the vertical perspective. Because of high transport and communications costs, individual contact with hundreds of small firms can be very expensive. Leveraging promotional efforts, by intervening in ways that affect a large number of small producers at a single stroke, reduces per-unit costs. By focusing on a single product market, subsector research facilitates the identification of constraints affecting a large number of small firms. And within a given subsector, the vertical perspective allows the analyst to seek out opportunities for highly leveraged interventions. It highlights "system nodes," the points at which a large volume of product passes through few hands or restricted geographic space. In many cases, for example, wholesale markets or distribution points offer opportunities for contacting dozens, perhaps hundreds, of small firms in a single visit. Similarly, a handful of key input suppliers can channel improved products or information to a multitude of small clients.

Subsector analysis begins with the selection of a product group in which small enterprises are important; selection is usually based on enterprise size, location, equity implications, or expected patterns

of change. The analyst must then identify the principal functions, participants, and channels of the product group. In the case of the sorghum beer subsector in Botswana, for example, the important functions (or vertical levels) include malting, brewing, and retailing. The key participants include home brewers (vertically integrated in differing degrees), commercial maltsters, factory brewers and retailers.

The subsector is disaggregated into a matrix of functions and participants delineating the principal channels through which raw materials are produced, transformed, and distributed to final consumers. The resulting grid is called the subsector map and it highlights the vertical relationships and competitive positions of subsector participants.

After outlining the subsector map, the next step is to identify overlays of special interest to the investigation. Common overlays include the number of enterprises, employment, sales, product volume, or inventory holdings within each function and channel. Other, less-quantitative, overlays can be included; tracing the variety of contract relationships in different channels or the sources of trade finance are examples.

By interviewing subsector participants and key informants, and supplementing with selective and focused data collection, it has been possible to gain a basic understanding of subsector dynamics in a relatively short time, often as short as two to four weeks. Three vantage points have proven especially valuable in viewing subsector dynamics. First, firms operating at system nodes — usually large wholesalers or input suppliers — are often well placed to observe changes in the system. Second, enterprise budgets reveal cost structures and sources of MSE competitiveness. They prove central to forecasting the rise and fall of alternative production and distribution channels. Third, consumption studies can be invaluable in estimating aggregate output across all channels, and in offering insights into future demand patterns.

To identify cost-effective interventions, one needs to look first for highly leveraged opportunities. Two commercial maltsters supply sorghum malt to 16,000 home brewers, with the potential to reach 40,000 more. Thus promoting improved malt through commercial maltsters offers a potential gearing ratio of 20,000:1. The possibility of rent-seeking behavior by commercial maltsters would need to be recognized in the design of a project with such an approach.

Four general policy implications emerge from these case studies. First, opportunities for policy reform are frequently subsector specific. General cross-industry studies normally fail to identify these opportunities for improvement through policy change. Second, policies may impinge on small firms indirectly, through input suppliers or output distributors as in Botswana where home brewers faced restrictions on their retailing activity. The vertical dimension of subsector research was crucial to detecting the policy constraint. Third, policies influence small firms through their effects on competing supply channels. The misapplication of licensing laws on behalf of large sorghum beer retailers is a clear example of this. In other settings, the availability of subsidized credit and tariff and tax benefits frequently confer advantages on large firms rather than their small-scale competitors. Fourth is the reminder that policies represent a classic application of leverage.

Practitioners must recognize the potential dangers present when high leverage is achieved via large firms. When a few large firms limit competition, rent seeking may seriously skew the distribution of project benefits. In some cases, contingency contracts or share contracts where donors or other sponsors participate in the benefits will be necessary to ensure performance that improves the position of MSEs.

Subsector research facilitates the understanding of major dynamics affecting MSEs, the identification of system blockages, and high-leverage intervention points. Moreover, these insights can often be gained relatively rapidly and at moderate cost. Two additional attributes also merit discussion.

First, subsector research can improve accuracy and reduce the cost of data collection. Its emphasis on data collection at system nodes frequently allows estimates of small firm activity with far greater precision than would be possible in a cross-section survey of small enterprises. For example, interviews with two maltsters in Botswana enabled projection of home brewing output of 16,000 home brewers. Moreover, assembling employment, volume, and budget overlays forces a juxtaposition of available data in ways not usually attempted. Reconciling the numbers frequently identifies candidates for improved data collection.

Second, the interventions identified in subsector analysis can often be characterized as "institutionally light." Because they focus on activities within one subsector, the interventions identified are often limited in scope, cost, time, and complexity. This, combined with their wide variety, suggests that subsector interventions may most appropriately be spliced onto existing organizations.

The authors consider subsector analysis to be a powerful tool for identifying cost-effective MSE interventions. Yet the approach has important limitations as well. Because subsector analysis focuses on system linkages and bottlenecks, it is less effective in analyzing constraints internal to the firm. Also, the vertical emphasis in subsector work makes it ill suited for the analysis of activities such as commerce, transportation, and finance, which cut across a great many vertical production and distribution systems. Finally, although it is recognized that vertical linkages strongly influence the competitive potential of small producers, the ability to analyze these coordinating mechanisms is still in its infancy. Certain variables consistently play a major role in influencing patterns of linkages among firms: economies of size in transactions; efficiency in retailing, packaging, and production; and the need to communicate product specifications. Other variables, such as the importance of trust, the need to minimize opportunistic behavior, and the effects of contracting methods, are much more difficult to evaluate. The role and importance of these variables in research is just beginning to be understood.

ANNEX J
REVIEWING THE POLICY ENVIRONMENT — DATA FOR
DECISION MAKING

According to the Data for Decision-Making Project analysis, collection of the following types of policy information was suggested:

- Public Provision of Health Services (extent to which public and private providers compete, at least by geographic area, and potentially by service and clientele).
- Public Financing of Health Services (grants to NGOs and contracts for private provision of clinical services).
- Taxation and Subsidies (direct taxation of final goods and services, tax deductions, tax on inputs, and other controls).
- Provision of Public Information (role of press in exposing corruption, and potential of increased consumer involvement by providing information).
- Regulation (process and procedures, degree of enforcement, effectiveness in meeting desired objectives, and impact on the functioning of the health market).

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ANNEX K
INTERVIEWS

Agency for International Development

Bob Emrey, HFS Project Officer
Catherine Gordon, INITIATIVES Project Officer
Craig Carlson, PROFIT Project Officer

Abt Associates, HFS Project Prime Contractor

Nancy Pielemeier, Zdrav Reform Project
Marty Makinen, Zdrav Reform Project
Jim Knowles
Abdo Yazbeck

Development Alternatives, Inc., GEMINI Project Prime Contractor

Joan Parker, GEMINI Deputy Director

Freedom from Hunger

Barbara McKnelly

Harvard University

Peter Berman, Data for Decision-Making Project

IMPACT Project

Bruce Cogill, Project Director
Shirley Buzzard, Consultant

InterAmerican Development Bank

Gerard LaForgia, HFS Consultant
Pedro Saenz

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Karanesh Tuli

John Snow, Inc.

Virginia Ward, INITIATIVES Project

Save the Children

Madeline Hirschland
Kirk Dearden, Research and Evaluation Officer

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