AN INVESTIGATION INTO THE USE OF VENTURE CAPITAL BY PRIVATE FOR–PROFIT MANAGED HEALTH CARE FIRMS (HMO's) IN KENYA

BY

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A MANAGEMENT RESEARCH PROJECT SUBMITTED TO THE FACULTY OF COMMERCE, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS OF THE DEGREE OF MASTER OF BUSINESS ADMINISTRATION (MBA), UNIVERSITY OF NAIROBI

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DECLARATION

I hereby declare that this Management Research Project is my original work and has never been submitted for any academic award in any institution of higher learning.

Signed .....

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This Management Research Project has been submitted for examination with my approval as the University Supervisor.

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DEDICATION

I dedicate this work to my late father Ngariuri Muriuki and my mother Lucy Ngariuri who never spared a coin to see me through school up-to University. Their love for education helped me to reach this far. To my beautiful and lovely wife Monicah Wanjiku for always being there for me even when everything seemed to fall apart. Her prayers and love was enough to push me forward.

PROLOGUE

"There is a time for everything, and a season for every activity under heaven:
a time to be born and a time to die,
a time to plant and a time to uproot,
a time to kill and a time to heal,
a time to tear down and a time to build,
a time to weep and a time to laugh,
a time to mourn and a time to dance,
a time to scatter stones and a time to gather them,
a time to embrace and a time to refrain,
a time to search and a time to give up,
a time to keep and a time to throw away,
a time to tear and a time to mend,
a time to be silent and a time to speak,
a time to love and a time to hate,
a time for war and a time for peace." Ecclesiastes 3:1-8

The Holy Bible, New International Version.

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ABSTRACT

This research project investigated the use of venture capital by for-profit health management firms in Kenya. The firms are important because their services are critical to the development of Kenya. Venture capital is provided to firms operating in risky sectors with high growth and return potential. This research established that these firms lack funds to provide affordable and comprehensive health care and venture capital is an important source that can alleviate this problem. A questionnaire was used to collect primary data from all the managed health care firms in Kenya. The study also established that bank loans and personal savings are the main sources of finance but firms avoid bank loans because of the high interest charged on them. Half the firms investigated used venture capital mainly for restructuring and expansion and 30% used venture capital to start their operations. Respondents indicated that the health Management sector is risky because of high variations in returns. This makes most financiers for example banks to charge high interest rates or give no loan at all and this makes it a fertile ground for venture capitalists. All respondents believe that existing venture capital firms need to create more awareness in Kenya about their operations. Major providers of venture capital in Kenya are foreign multilateral institutions and the main determining factor for a venture capitalist to invest is the product/service and returns.

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CHAPTER I

1.0 INTRODUCTION

1.1 Background

Good health is both a basic right and a prerequisite for socio-economic development. A sound health care system, good nutritional status, food security and the absence of epidemic diseases are conditions that produce healthy people capable of participating in a country's economic, social and political development. There is a direct relationship between the health of a population and its productivity as a result of investing in health care services (Kimalu, 2001). However, implementation of health programmes in Kenya has been hampered by inadequate resources in the health sector (GOK, 2002).

The ambitious free medical services initiated by the government after independence in 1963 has not been sustainable. Population increase and the demand for health care outstrip the ability of the government to provide effective service. Worse still, the HIV/Aids pandemic is now a major threat to growth. The health sector therefore has not been able to expand as rapidly as the population to ensure adequate coverage, accessibility and acceptable quality of health services (Kimalu, 2001). According to the Kenya Human Development Report of 1999, government financing of health care amounts to 60% of what is required in order to provide minimum health services. This implies that health care delivery in Kenya is under funded.

The government finances 50% of health care costs while private payments cover 42% and donors, non-governmental organizations (NGO's) religious organizations and other private institutions provide 8% of recurrent health care costs (Kimalu, 2001).

Reduced government revenues and donor support has necessitated the development of alternative methods of health care financing particularly by the private sector (Owino, 1999). The government is therefore encouraging the private sector to play a greater role in the delivery and financing of health care services while the ministry of health concentrates on policy formulation and regulation of activities (Owino, 1999). Through this selective privatization, the government is able to reduce its commitments in the health sector (EIU, 1995).

The private sector medical service provision is gaining prominence even more because of deterioration of services and conditions in the public sector since the 1980's (Owino, 1999). However the central problem facing the private sector is inadequate resources both human and financial (Vogel, 1990, Shaw, 1995, Mati, 1997). Since adequate funding is essential in the provision of adequate health care for all (CBK, 1991), health insurance is one in a portfolio of options that are available to augment government budgetary resources for health care spending (Vogel, 1990).

1.2 Health Care Provision in Kenya

On attaining independence in 1963, the government of Kenya committed itself to providing free health services as part of its development strategy to alleviate poverty and improve the welfare and productivity of the nation. This pledge was honored in 1964

with the discontinuation of pre-independence health–user fees and the introduction of free outpatient services and hospitalization for all children in public health facilities. Services in public health facilities remained free for all except those in employment whose expenses were met by the employers (G.O.K, 2001).

Adverse economic changes in the past, coupled with new health challenges have led to a reversal of the policy of offering free health services by the government and the need for overall health sector reforms. A key challenge is how to ensure access to affordable health care for all Kenyans. In the first two decades after independence, Kenya's health infrastructure and service coverage grew rapidly (G.O.K, 2001).

In 1965, the government abolished fee collection in public health facilities and went ahead in 1970 to take over health centers and dispensaries previously run by local authorities. All these facilities were taken over under the Ministry of Health. However a corresponding transfer of the relevant budget did not accompany this take over from local authorities to the Ministry of Health (G.O.K, 2001).

The government through the ministry of Health exercises general oversight responsibility for the health of the population. The Ministry of Health (MOH) is responsible for national health policy. It is also the largest provider of health services in the Kenyan health care system. The MOH consists of two wings, the administrative wing headed by the Permanent Secretary and the professional wing headed by the Director of Medical Services (DMS). The Permanent Secretary is responsible for planning, budgeting and

development while the DMS is responsible for hospitals and other health facilities, training and medical research.

The medical practitioners and dentists Board under the chairmanship of the DMS is responsible for approving private hospitals and clinics and for the overall supervision of the practice of medicine by qualified physicians and dentists in the country. A senior Deputy Director of Medical services is responsible for co-ordinating non governmental organisations (NGO) and private health provider activities.

Kenya is divided into eight administrative provinces and a Provincial Medical Officer (PMO) oversees the health system of each province. He is also responsible for co-ordinating government and non-government health services and for the overall administration of GOK health facilities in the province. The health system in the district is administered by a District Medical Officer of Health (DMOH).

The Health Information System (HIS) database of the Ministry of Health lists the following types of health facilities: hospital, health centre, sub-health centre and dispensary.

Hospitals

Hospitals are NHIF-approved for inpatient reimbursement and are expected to provide both curative inpatient and outpatient care. But they vary in the range and quality of services they provide. They mainly have paediatric, intensive care, maternity and general wards and some are equipped with the state of the art technology. The Kenyatta National

Referral Hospital (KNH) which serves as a teaching and a referral Hospital is at the top of all hospitals in Kenya followed by Moi National Referral Hospital in Eldoret. The provincial Hospitals serve as a link between the district hospitals and the national referral hospitals.

Health Centres

By definition health centres are expected to provide mainly primary care with some limited inpatient capabilities. Those health centres which provide inpatient services can be NHIF-approved and make claims from the NHIF.

Dispensaries

These facilities provide largely outpatient services. Dispensaries provide limited outpatient curative services in addition to dispensing drugs. They do not provide inpatient services and therefore do not receive reimbursements from the NHIF.

Sub-Health Centres

There has been an increase in the number of sub-health centres. This is largely attributable to a government decision in 1989 to allow nurses and clinical officers to enter private practice. All of the sub-health centres provide outpatient care although a few have minimal inpatient facilities.

The following table gives the number of various health facilities and hospital beds and cots in Kenya by province.

Table 1
Health institutions and hospital beds and cots by province

Province	Hospitals	Health Centres	Health Sub-Centres and Dispensaries	Total Facilities	Hospital beds and Cots	
					Number	Number for 100,000 Population
Nairobi	56	53	376	485	4891	21.2
Central	63	56	368	517	8191	22.4
Coast	64	40	331	435	7687	30.6
Eastern	63	79	689	831	7412	15.3
Northeastern	7	11	65	83	1707	14.0
Nyanza	97	114	328	539	11922	23.1
Rift Valley	98	259	1002	1259	12390	16.2
Western	66	92	192	350	6457	19.1
Total	514	634	3351	4499	60657	19.2

Source: GOK, Economic Survey, 2003.

The table below gives the number of medical personnel by category in Kenya.

Table 2
Registered Medical Personnel.

Type of Personnel	Number	Number per 100,000 Population
Doctors	4740	15.1
Dentists	761	2.6
Pharmacists	1866	5.9
Pharmaceutical Technologists	1319	4.3
Registered nurses	9753	31.0
Enrolled nurses	29094	94.6
Clinical officers	4778	15.2
Public health officers	1174	3.3
Public Health Technicians	5484	17.3
Total	59049	189.1

Source: GOK, Economic Survey, 2003.

Health insurance in Kenya is provided by the government and the private sector.

Government provision is through the National Hospital Insurance Fund (NHIF).

1.3 National Hospital Insurance Fund (NHIF)

The National Hospital Insurance Fund (NHIF) was set up by an act of parliament, Cap 255 in 1966. Its mission is to support the financing of healthcare and related services in Kenya. It collects contributions from all Kenyans earning an income of over Ksh.1000 and pay hospital benefits out of the contributions to members and their declared dependants (spouse and children).

Prior to 1966 there was a discriminative scheme meant to cover Europeans, Arabs and Asians. A series of amendments have been made to the original Act at different times to accommodate changing healthcare needs of the Kenyan population, employment and restructuring in the health sector. In 1972, the Act was amended to incorporate voluntary membership. In 1990, the Act was repealed to allow contribution on a graduated scale of income. In 1998, the old Act was repealed and transformed NHIF into a state corporation, delinking it from the Ministry of Health, where formerly it was a government department.

The current Act makes provisions for in-patient and outpatient benefits to members. However, currently the Fund only provides for an in-patient cover and is undertaking actuarial studies to determine the feasibility of establishing an outpatient cover for its members. Under the in-patient scheme, NHIF pays benefits to accredited hospitals and health providers in respect of its members and their declared beneficiaries.

The Fund is mandated under the new Act to invest funds in programmes aimed at improving the quality of health care in the country. Intended beneficiaries are both public and private hospitals and other stakeholders. The money can be

invested in the procurement and acquisition of essential medical equipment for provision to hospitals. In addition, the fund is working out modalities of establishing a hospital loans programme, where declared hospitals can borrow loans to improve the quality of healthcare they are offering NHIF members. In mid 2001, NHIF donated 83 ambulances through the Ministry of Health to public and mission hospitals countrywide. The Fund has also held several free medical camps in some of Kenya's remote areas and given drug donations to health facilities in these areas.

The NHIF Act gives the fund power to declare/accredit hospitals where contributors can seek services. Currently, about 400 hospitals and health providers that offer general, specialised and emergency healthcare services are accredited by the Fund. Accredited institutions are those legally recognized by the Fund in respect of claims made by contributors or hospitals. Refunds cannot be made for health care services sought in non-accredited hospitals.

The Fund regularly inspects these facilities to ensure quality is maintained in the services that contributors receive as well as to avoid contributors from being overcharged. The criteria used in determining the benefit rates for these hospitals and health providers, is based on facilities available. These include X-rays, Intensive Care Unit (ICU), overall area occupied, separate wards for children, males, females, isolation wards, number of doctors, nurses and clinical officers, supply of electricity and availability of stand-by generators, ambulances, pharmacies, laboratories, and operating theatres.

The private health Insurance firms are divided into two:

a) Firms providing health insurance alongside other insurance businesses and are registered under the Insurance Act.

b) Firms providing health insurance only but can also own hospitals, chemists and laboratories generally referred to as Health Management Organizations (HMO's).

Health Insurance is the process of transferring the cost of future incidences of ill health to a risk undertaker in exchange for a specific smaller payment or premium. This presumes that the risk undertaker has analysed the random size and frequency of the risk, measured it, classified it, provided for its impact on cash flow, solvency and profitability or sustainability by appropriate reserving methods and priced it.

Private sector providers include insurance companies and health management organisations (HMO'S), hospitals and private sector organisations by means of staff allowances. Health Management Organizations (HMO's) are organised systems of healthcare that provide an array of medical services on a prepaid basis to voluntarily enrolled persons. HMO's act like insurance companies in that they finance healthcare. Insurance companies are in the business of providing financial protection to property, life, health, fire, motor vehicles and other risks that face individuals, corporations, governments and other entities. The insured person in an insurance contract pays regular premiums in return for a policy guaranteeing such protection. However, unlike Insurance companies, HMO's also deliver medical services through ownership of hospitals, health clinics, diagnostic laboratories and ambulance services. HMO's are registered only under the Companies Act. However, in order to operate hospitals, health clinics, diagnostic laboratories and pharmacies, they are required to be licensed under the Health Act.

The Minister for Finance has proposed to bring all HMO's under the Insurance Act (GOK, 2002). The implications of the proposal are that HMOs, which are involved in medical insurance, shall have to raise their capitalisation base to Ksh100 million, the minimum required of an insurance firm in Kenya. My research has found that 80% of the HMO's have annual turnovers of Ksh.100 million or less (table 3). According to the Association of Kenya Insurers (AKI) few of the Kenya's existing HMOs can raise that kind of money (capital) easily, implying that they will fold up, merge or concentrate on the provision of medical care like conventional clinics. Other stakeholders in the medical and insurance sectors, including the Kenya Medical Association (KMA), have stated that this situation exposes Kenyans to rip-offs, including high premiums and exposure to fake firms (Kimani, 2002).

Further, the capital base of these organisations and their solvency levels may not be able to support the random size and frequency of claims, and at the same time meet unregulated operating costs which are usually very high (AKI, 2001). In 1998, according to AKI Kenya's then second largest health insurer, Medivac, collapsed following a piling up of liquidity problems, leaving an estimated 40,000 members uninsured. International Private Healthcare a HMO has also closed after collecting premiums from the public.

According to (Kimani, 2002) the proposal to make HMOs answerable to the Commissioner of Insurance is intended to redress the oversight that HMO's currently transact medical insurance business in Kenya without regulation and supervision. At the same time the Kenya Medical Association (KMA) contends that because of a regulatory

vacuum, Kenyan HMO's often engage in medical insurance practices that would be unacceptable in more developed markets (Kimani, 2002).

The Association of Kenya Insurers (AKI) gives the following reasons in support of regulation of HMO's:

1) To ensure that HMO's remain solvent and can guarantee the obligations that they have assumed. When a HMO accepts a premium payment or membership fee, it technically incurs a liability. The liability is the obligation to pay claims as they arise and the HMO should earmark funds to represent the liability. HMO's should be legally required to demonstrate that such funds are actually available. Without such a requirement, unwise or even illegal investment practices could enable the HMO to use its funds in a way to endanger the guarantee that claims will be paid promptly and in full.

2) To ensure that HMO's are fair and ethical in their treatment of consumers or members. In order to do this, HMO's products should be required to meet certain standards before they can be offered to the public. The standards should govern the benefits provided, contract wording, the reasons that may be used to deny claim payment and the manner in which the HMO sells and administers the products. Currently there is no authority to which an aggrieved member of a HMO can turn to for help.

3) To create a level playing field. Lack of uniform regulation creates an uneven playing field in the provision of health Insurance. On the one hand are insurance companies who operate under the Insurance Act and on the other hand, are HMO's who have no regulating authority.

4) To protect consumers or members in the event of collapse of the HMO.

Medivac continued to accept new members until it went into voluntary liquidation in July 1998. No government agency has ever moved to investigate the reasons for the collapse or to protect the members.

1.4 Venture Capital

Venture capital is high-risk equity in which the investor actively or partially participates in the venture being financed. The objective is to add value during the financing period so that the venture capitalist can sell his share later with positive returns. Venture capital is flexible and imaginative in the financing packages that are put together than the banking sector. The contribution of venture capital includes help to companies in restructuring during the process of growth, finding suitable management and assisting in rescue packages (Sami-Al Suwailem, 2000).

Equity financing is an exchange of money for a share of ownership. It generally comes from investors who expect little or no return in early stages but require more extensive reporting as to the company's progress. The major disadvantage to equity is dilution of ownership and possible loss of control that may accompany sharing of ownership. Debt financing means borrowing money that is repaid over a period of time, usually with interest. Debt carries the burden of monthly payments whether or not you have positive cash flow. Debt financing is available to all types of businesses but risky businesses have to pay high interest rates. Debt financing does not sacrifice any ownership interests in the business.

HMO's can greatly benefit from venture capital financing because venture capitalists;

(i) Provide expertise.

(ii) Provide equity funds, which do not require periodic payments like debt capital.

(iii) Help firms' start-up, grow or expand whenever the owner has a need.

1.5 Research Problem

The for-profit managed health care firms (HMO's) in Kenya require financing in order to provide a wide array of medical services and the proposal to put them under the Insurance Act implies they would require more funds to meet the minimum capital base. In view of the above this research intends to provide answers to the following questions;

(i) Are For-Profit Managed Health Care firms aware of venture capital financing?

(ii) What is the extent of the for-profit managed health care firms' use of venture capital?

(iii) What is the for-profit managed health care firms' attitude towards venture capital financing?

(iv) What problems affect venture capital financing in Kenya?

1.6 Objectives of the Study

The objective of the research was to study various aspects of venture capital financing that apply to for-profit managed health care firms (HMO's). It also intended to determine the extent of usage of venture capital by managed for-profit health care firms in Kenya.

1.7 Justification for the Study

The health sector of any country is important because a healthy nation means a healthy working population. However to achieve the healthy status desired by all, financing of healthcare becomes critical. It is this need for financing that this research sought to establish the role of venture capital in the HMO sector.

1.8 Importance of the Study

The study is of importance to;

- Existing and potential private for profit health care providing firms. It will assist existing firms by providing literature about venture capital financing and its role in assisting firms meet financing requirements at any level of their development.
- The government

The government will benefit by realizing the role of venture capital financing in health care provision. It will gain by developing policies that favour the growth of venture capital and the private for profit health care firms.

- Research scholars particularly in the area of health and health care financing.

Researchers in the area of health and health care financing will have ready material on venture capital and its role. This forms the basis of further research and comparison with other forms of health care financing.

- Existing and potential venture capitalists

Venture capital providers will gain an understanding about the operations of health care firms. They will understand why they use or do not use venture capital. This will help them develop proper programmes to suit the operations of health care firms.

1.9 Research Report

The research report is divided into five chapters:

Chapter 1 Introduction

The chapter covers the background of the study, managed health care in Kenya, the case for regulation of HMO's in Kenya, venture capital, research problem, objectives and importance of the study.

Chapter 2 Literature review

It deals with past research in Kenya about venture capital, definitions of venture capital, history of venture capital in the world, types of venture capital, features of venture capital, venture capital investment process, venture capital in Kenya, benefits of venture capital and managed health care.

Chapter 3 Research design

The population of the study, data collection and analysis methods for the research project is dealt with here.

Chapter 4 Data analysis and findings

The chapter gives details on the population characteristics, sources of finance, venture capital awareness and use, attitudes towards venture capital and their benefits, venture capitalists concerns and investment criteria and venture capital in Kenya.

Chapter 5 Summary, Limitations and recommendations.

A summary of the research findings, limitations to the study encountered and recommendations for further research is explained.

CHAPTER II

2.0 LITERATURE REVIEW

2.1.0 Past Research on HMO's in Kenya

The Summa Foundation commissioned a case study to examine the impact of a loan that it made to AAR Health Services. The case study examined the success of the loan in achieving positive health outcomes and the cost effectiveness of this intervention. The study concluded that financing is an innovative intervention with the private sector that can achieve positive health outcomes, such as the sustainable delivery of family planning services, at no cost or very low cost.

2.1.1 Introduction

There has been much discussion on the role of private providers in health care delivery in developing countries. Even under the current pro-private sector environment, there is not adequate research on how to support for-profit providers in ways that produce cost-effective public health outcomes. Historically, these for-profit providers have mainly focused on curative care. Increasingly, however, for-profit providers are playing a larger role in delivering health services with public health outcomes, such as immunization or family planning. In many countries, however, there are a number of impediments that have constrained the growth of the private sector. In some countries there are demand generation, willingness to pay issues and regulatory constraints. In some cases, the private sector has also been slow to invest because it perceives lower income populations or certain types of services, such as family planning, to be less profitable or riskier.

The private sector has also been constrained by lack of financing. Commercial banks are often reluctant to lend to the private health sector. In order to grow, many private providers are limited to their own savings or borrowing from friends and family. In an environment of limited or uncertain financial rewards, external intervention may be required to encourage for-profit private providers to provide services with positive public health outcomes. One of the approaches that has been used to motivate the private sector is the provision of financing, through loans or equity investments.

The provision of financing has been used not only to address the access issue but some of the other impediments listed above. Understanding the impact of financing on alleviating impediments on the private sector is useful for improving the design of future interventions. In a limited funding environment, it is not only important to examine whether financing can produce positive health outcomes, it is also important to see how the outcomes compare with the costs.

2.1.2 Goals of Intervention

Summa's long-term goals of this intervention were the following:

1) Integrate a full range of family planning services, including pills, barrier methods, spermicides, female sterilization, and vasectomy into AAR's package of prepaid services

2) Increase the number of new family planning acceptors.

3) Contribute to the sustainable delivery of family planning services by the private sector.

4) Shift family planning service provision from the public to the private sector

5) Assist AAR to enter a lower income market

2.1.3 Description of Intervention

The Summa Foundation provided a loan to AAR to establish a clinic system in the industrial area in Nairobi. Proceeds from the loan were used to build and equip a medical center and outreach clinic, as well as to support related activities, such as market research, and computer systems to support operations. The total value of the loan was Kshs 23 million.

2.1.4 Success in Achieving Goals

Goal 1: Integrate a full range of family planning services into AAR's package of services

The Summa loan was very successful in integrating family planning services into AAR's prepaid package.

Goal 2: Increase the number of new family planning acceptors.

The Summa loan had a more limited success in increasing the number of new family planning acceptors.

Goal 3: Contribute to the sustainable delivery of family planning in the private sector. Although the loan had a modest impact on creating family planning demand, by motivating AAR to introduce services, it created a continued expectation of such services from its members. Family planning has become entrenched in AAR's overall services, and is unlikely to be discontinued even after the loan is repaid.

Goal 4: Shift family planning service provision from the public to private sector. The Summa loan to AAR was less successful in shifting family planning service provision from the public to the private sector.

Goal 5: Assist AAR to enter a lower income market.

The Summa loan was successful in assisting AAR to enter a lower income market. Before the Summa loan, AAR almost exclusively served an upper income market, targeting their prepaid package of high quality services to managers of multinational corporations and other high-income population groups.

2.1.5 Analysis of Cost Effectiveness

This intervention is very different from traditional public health interventions because it is a loan. The calculation of the costs must also factor in AAR's repayments. AAR has made full and timely repayments to the Summa Foundation. Specifically, Summa was able to integrate family planning services into a pre-paid package of services that will be delivered on a sustainable basis through the private sector. Summa was able to motivate a commercial company to offer high quality health services to a lower income population group.

2.1.6 Lessons Learned

Providing financing to a for-profit company to motivate it to provide family planning services can be a cost-effective way to increase new family planning acceptors and deliver family planning services. Financing can remove some of the obstacles to for-profit providers' reluctance to provide certain health services. Financing is more successful at addressing process obstacles (such as lack of training or capital), than structural obstacles (such as lack of market demand or financial incentives). In some cases, it may be necessary to combine financing with targeted technical assistance in order to overcome structural obstacles.

The Summa loan was successful in motivating AAR to offer family planning services, but did not provide an incentive for AAR to promote these services. A managed care organization will promote certain services if providing such services can help avoid future more expensive treatment (for example, childhood immunization or early malaria treatment). Family planning could be comparable to other preventive services if the provider was responsible for coverage of costs related to childbirth providing family planning is a low-cost way to prevent a more expensive delivery. More research should be conducted on how to link family planning to a significant increase in revenue or reduction in costs for a for-profit provider. A commercial partner will expand to lower income groups if it is profitable.

Financing can be used to share risk and encourage the commercial partner to enter a new market. The intervention caused fewer clients to switch from public providers than was originally anticipated. Further research to explore the explanations for this outcome would be useful since one of the goals of working with private providers is often to encourage users to switch from public providers. Targeted promotion to public sector users may be necessary. In order to lower the cost of this kind of an intervention or increase the positive return, it is important to consider costs when setting the interest rate and payment terms.

Depending on the method for analyzing costs, the Summa loan to AAR Health Services produced family planning and other positive health outcomes at no cost or very low cost. It also demonstrated that more innovative interventions with private providers should be considered as they can be more cost effective than traditional programs. Financing can be

used to motivate the private sector to achieve public health outcomes. Attention should be paid to how the financing is structured and to selecting the appropriate partners.

2.2.0 Definition of Venture Capital

Venture capital is a form of active investment through high-risk equity-based instruments. Venture capital financing is praised for its role in promoting growth while maintaining financial stability. The objective is to add value to the recipient company during the financing period, so that the venture capitalist can sell his share later on with positive returns (Sami AL- Suwailem, 2000). Venture capital funds provide finance for high growth potential unquoted firms and it is a medium to long-term investment (Arnold, 1998).

Venture capital plays a strategic role in financing small-scale, high technology and risky ventures. It is a significant innovation of the 20th century and a synonym of high risk capital (Pandey, 1999). Venture capital funds provide start-up capital for new or existing high-risk businesses having high profit potential. Venture capital managers provide significant oversight and input to the target companies. Venture capital is money invested in a new business by people who usually have no interest in managing the firm but offer advice (Schall, 1986). Such investment is exposed to greater than normal probability of losses and consequently banks, insurance companies, and trusts keep away from them (Van Horne, 1973). Venture capital is provided by professionals who invest alongside management in young rapidly growing companies that have the potential to develop into significant economic contributors (India Infoline, 2001).

2.3.0 Brief History of Venture Capital

2.3.1 Georges Doriot

When venture capital was a new style of investing in the 1950s, the first institutional investor to attract money for it was American Research and Development (ARD) in Boston. This company was the invention of General Georges Doriot, a naturalized American from France. He was a senior professor at the Harvard Business School who had served in the American Army during World War II.

Gen. Doriot, taught a class called 'Manufacturing', which was a mini-version of what he considered a full Master of Business Administration (MBA) curriculum should be. He attracted only top students and demanded that they give his course their highest priority. Students engaged in a major group project of original work, which elsewhere would have been considered a thesis. These projects often resulted in new companies being formed by students following graduation and Federal Express is one of them.

Gen. Doriot also served as an active chairman of ARD, the first publicly traded venture capital investor. It was usually the lead investor and did participate with other investors. During the 1960s, the ARD portfolio had approximately one hundred positions. It is important to note that only two investments - Digital Equipment and High Voltage Engineering - produced almost all the gains.

There were two lessons about venture investing that Gen. Doriot emphasized. First, invest very carefully but expect that your success ratio will be a tiny fraction of the number of investments. Therefore, run wide, diversified portfolio. Second, prepare to spend time and resources to monitor and nurture your investments during the time you are invested. His intended investment horizon was perpetual, although his theories

suggested that as companies became able to stand on their own feet, ARD should recycle the money elsewhere.

Venture investment is now highly specialized with some investing in startups, mezzanine investing for companies preparing to raise public market money, others concentrating in particular industries and still others tie advice and money in a style that would have been approved by Gen. Doriot.

2.3.2 J. H. Whitney

The ability to create and foster new businesses has been the appeal of venture capital since its creation in 1946 by the privately held J. H. Whitney and Company and the publicly traded American Research and Development Corporation (ARD). Prior to this, funding for new ventures came mainly from wealthy individuals or from the government.

John Hay Whitney, who established Whitney and Company with four others, was a scion of an enormously wealthy family. He also was an internationally ranked polo player, art collector, and an investor in theaters and motion pictures. He funded Pioneer Pictures and helped to establish the Selznick International Motion Picture Company, which produced "Gone with the Wind." As a publisher, he funded Scientific American and Newsweek, among others, and published the New York Herald Tribune, the famed competitor to The New York Times.

Although Whitney invested in a few private companies before the war, he realized that a more formal process of venture capital investment would be needed if American businesses were to thrive in the new postwar economy. Whitney envisioned a systematized flow of capital from wealthy individuals to qualified new ventures, with the mission of encouraging new ideas and technologies. This would help the wealthy meet

their societal obligations, and the success of the venture capital system might be better assured by having professional venture capitalists manage the funds they invested in new enterprises. This signaled the birth of venture capital as a comprehensive business strategy and philosophy.

Portfolio companies were carefully chosen, Whitney rejected 99 percent of all proposals, accepting the remaining few not only for what they made, but also for the managerial quality of their founders. Among the 350 companies that Whitney helped develop were Minute Maid, Compaq Computers and The North Face.

2.4.0 Types of Venture Capital

Venture capital can be grouped in the following ways according to (Pandey, 1999),

i. *Seed corn* This is financing to allow the development of a business concept. Development involves expenditure on production of prototype and additional research.

ii. *Start-up* A product or idea is further developed and or initial marketing carried out. Companies are very young and have not yet sold their product commercially.

iii. *Other early – stage* These are funds for initial commercialization, manufacturing and sales. Many firms at this stage will remain unprofitable.

iv. *Expansion* Companies at this stage are on a fast growth track and need capital to fund increased production capacity, working capital and further development of the product or market.

v. *Management buyouts (MBO)* Here, a team of managers makes an offer to their employers to buy a whole business, a subsidiary or a section so that they own or run it for themselves. Large firms do these if the business is under performing and does not fit in

with the strategic core business. The management team has limited funds and requires venture capital.

vi. *Management Buy-ins (MBI's)* A new team of managers from outside an existing business, buy a stake, usually backed by venture capital. A combination of MBI and MBO is BIMBO, where a new group of managers join forces with an existing team to acquire a business.

2.5.0 Features of Venture Capital

(India Infoline 2001) gives the following as the features of venture capital,

i. *Equity participation* Venture financing is an actual or potential equity participation through direct purchase of shares, options or convertible securities, the objective is to make capital gains by selling off the investment once the enterprise becomes profitable.

ii. *Long-term investment* Venture financing is a long-term illiquid investment. It is not repayable on demand but requires long-term investment attitude and one waits between 5 – 10 years to make large profits.

iii. *Participation in Management* Venture financing ensures continuing participation of the venture capitalist in the management of the business. This helps him protect and enhance his investment by actively supporting the entrepreneur. He also gives his marketing, technical, planning and management skills to the new firm.

2.6.0 Venture Capital Investment Process

(India Infoline 2001) gives the following as the venture capital investment process even though variations can occur from one case to another.

i. *Deal origination* In generating a deal flow, the venture capital investor creates a pipeline of deals that he would consider for investing in.

ii. *Due diligence* This refers to all the activities that are associated with evaluating an investment proposal. It includes carrying out reference checks on the proposal related aspects such as management team, products, technology, market etc. Due diligence focuses more on qualitative aspects of an investment opportunity.

iii. *Investment valuation* The investment valuation process is an exercise aimed at arriving at an acceptable price for the deal. It could entail evaluation of future revenue and profitability, future firm value etc.

iv. *Structuring the deal* Structuring refers to putting together the financial aspects of the deal and negotiating with the entrepreneurs to accept a venture capital's proposal and finally closing the deal. To do a good job in structuring a deal, one needs to be knowledgeable in areas of accounting, cash flow, finance, legal and taxation.

v. *Monitoring and follow-up* The skills of the venture capitalists are most required once the investment is made. The venture capitalist gives ongoing advice to promoters and monitors the project continuously.

vi. *Exit* Exit from the investment varies from investment to investment and from venture capital to venture capital. There are several exit routes, buy-back by the promoters, sale to another venture capitalist, sale at the time of initial public offering etc. In all cases, specialists will work out the method of exit and decide what is most profitable and suitable to both the venture capitalist and the investee unit.

2.7.0 Venture Capital in Kenya

Kenya has had a venture capital sector since independence in 1963 (Ngigi, 1997). The venture capital sector began with the following government institutions;

2.7.1 Industrial Development Bank (IDB)

Industrial Development Bank (IDB) is a wholly owned government institution. It was established in January, 1973 by the Government of Kenya with the support of the World Bank. Its purpose is to further the economic development of Kenya by financing industrial enterprises mainly using foreign currency resources. IDB's mandate and mission is to promote economic and industrial development of Kenya by providing long term finance and accompanying financial services to medium and large scale industries in a manner that ensures profitability, liquidity and sustainability. This objective of the Bank is achieved by using funds mobilized both domestically and abroad. Over time the Bank diversified and offers a wider range of products and financial services to industrial projects (IDB, 2002).

The bank's corporate mandate has been enunciated in the bank's statement of policies and operating procedures which has been adopted by the Board. According to this statement the mandate of the bank is achieved through the provision of-:

a) Medium and long-term loans,

b) Working capital, machinery finance and export trade related banking facilities, and

c) Corporate advisory services.

The principal activity of IDB is medium and long term lending. The minimum loan size for first time borrowers is Kshs.10 million. The bank does not invest in a project or group in which its maximum exposure is more than Ksh.75 million. While the bank assists all business sectors, it concentrates on financing the expansion, modernization, balancing and diversification of successful projects with a proven track record (IDB, 2002).

The bank gives preference to those projects with positive employment and balance of payments features for the Kenyan economy. All projects are, however, required to be economically sound, financially viable, technically feasible and those with or willing to engage competent management (IDB, 2002).

2.7.2 Kenya Tourist Development Corporation (KTDC)

Kenya Tourist Development Corporation (KTDC) is wholly owned by the government. The Kenya Tourist Development Corporation Act (Cap 382) outlines the powers and scope of the operations for the Corporation, including the investigation, formulation and carrying of projects for developing the tourist industry in Kenya. In pursuance of its functions, the corporation operates commercial loan programmes and revolving fund programmes. The objective of the revolving fund is to assist Kenyan entrepreneurs to become more competitive in the tourist sector in line with the government policy to Kenyanise not only the tourism sector but also the entire industrial and commercial sectors of the economy (KTDC, 2002).

This programme is geared towards raising the standard of the tourists accommodation and other facilities as well as ensuring a more equitable balance in the distribution of

hotels and lodges in all parts of the country to serve the needs of the tourist and business sector. Business loans (B.L) are provided for tour operations vehicle, curio shops, handcraft trade and related projects. Development Loans (D.L) are offered for development of new tourist facilities, hotels, restaurants or lodges. Kenyanisation loans are given to assist purchase of existing tourist facilities from foreign ownership while modernization and extension loans are for purchase of existing facilities such as hotels, lodges, or restaurants (KTDC, 2002). Under commercial loans programme, loans are advanced to well established tourist enterprises including high-class hotels and travel organizations again to facilitate realization of the objectives.

Financial assistance is eligible to all Kenyans. In case of limited liability companies and partnerships, a venture is deemed Kenyan if 51% or more of its shares are held and owned by a Kenyan (KTDC, 2002). KTDC does not take over loans from the other lenders. However, co-financing with other financial institutions can be permitted only in cases of an expansion of existing projects where satisfactory financial results have been clearly demonstrated but working capital from commercial banks is not considered part of co-financing (KTDC, 2002).

2.7.3 Development Bank of Kenya (DBK)

Development Bank of Kenya (DBK) main objective is to make contribution to the development and expansion of Kenya's industrial sector in order to help stimulate the country's economic progress within the overall framework of the government's development policy. It emphasizes the creation of new productive assets, and the maintenance or improvement of existing capacity through project expansions,

diversifications and refurbishment programmes. In the evaluation of projects for investment, the broad criteria of commercial viability and development value are given particular attention (DBK, 2002).

The Firm provides medium and long-term foreign currency loans or equity capital to industrial enterprises, but it does not engage in the refinancing of existing projects. It gives financial assistance to only private or public companies and not to individuals, partnerships or proprietorship (DBK, 2002).

2.7.4 Industrial and Commercial Development Corporation (ICDC)

Industrial and Commercial Development Corporation (ICDC) was established in 1954 and assigned the task of assisting Kenyans to actively participate in the economic development of the nation. The corporation has put in place a number of small scale programmes which have enabled thousands of Kenyans to set up commercial and industrial enterprises throughout the country (ICDC, 2002).

Along or in partnership with other investors, ICDC has promoted over 60 medium and large-scale projects in all sectors of the economy. These projects now constitute an important foundation upon which development can be built. To facilitate the industrial and economic development of Kenya, ICDC is mandated to provide;

a) Venture capital finance in a minority capacity. This is subject to percentage of ICDC shareholding in any client company not greater than 40% of paid up ordinary share capital (ICDC, 2002).

b) Secured long – term finance and export financing. As part of the conditions, lending rates are pegged to the ruling market rate.

c) Management Advisory (Consultancy) services. ICDC provides general management advisory services on various disciplines

In keeping with the need to operate on a more commercial footing, the corporation has undergone a major restructuring exercise to enhance its effectiveness and profitability in an open market (ICDC, 2002).

2.7.5 Kenya Industrial Estates (KIE)

Kenya Industrial Estate (KIE) is wholly owned by the Government and specializes in providing loans for small enterprises. It was established in 1967 as a subsidiary of ICDC but was reconstituted in 1978 as an independent financial institution and principal government agency for promoting small-scale industries throughout the country.

It does this through;

a) Enhancing acquisition of skills necessary for industrial development

b) Technological innovations through research.

c) Providing capital necessary for industrial development

d) Providing guarantees for loans to be used for industrial development especially for small-scale industries (KIE, 2002).

KIE promotes entrepreneurship by financing and developing small Jua Kali enterprises owned and managed by indigenous Kenyans. This mission is achieved through provision of credit and consultancy services. It expects the business to be owned and managed by indigenous Kenyans, located within the republic of Kenya, be a start or expansion,

economically viable and technically feasible. Kenya Industrial Estate helps to raise finance both from local and/or foreign sources. At the moment the government is the biggest donor but the programme has been assisted substantially by World bank and other international donors (KIE, 2002).

2.8.0 Benefits of Venture Capital

Venture capital funds are considered national treasures due to the success they have enjoyed over the years in identifying, financing and nurturing to maturity many of the best known high technology start-up companies including Intel, Federal Express, Microsoft etc (Gompers 1992). According to (Bygrave, 1992) and (Manju, 2000) venture capitalists are more useful in starting up new businesses since they also provide professional guidance. Economic development for states is also linked to availability of venture capital to local entrepreneurs and businesses (Gaston, 1990).

Sufficiently high incentives for risk sharing would induce some high quality entrepreneurs to accept the average bid by the venture capitalist (Amit, 1990). Many high quality entrepreneurs, although innovative and productive, lack the required experience in management, marketing and financial planning. In this case, the entrepreneur might be willing to accept venture capital in compensation for the experience and contacts of the venture capitalist. (Warne, 1988) shows that, if assistance cannot be acquired through a competitive market and in the presence of asymmetric information, entrepreneurs would be willing to pay more for venture capital than for a loan without assistance.

A related factor is the reputation that the entrepreneur would get by obtaining venture capital. Such reputation helps the entrepreneur to obtain further capital in the future at a lower cost than otherwise. For example, venture backed initial public offering (IPO's) are generally better valued than non-venture backed IPO's. Venture capital promotes stable financial conditions for the fledging firm. It also fosters policies which may lead to higher returns on investment i.e. profit rewards and incentives for investors and entrepreneurs alike.

According to (Schumpeter, 1942), a driving force for growth is innovation. Venture capitalists are able to explore territories and break barriers that traditional financiers because of the lack of information and high risks, are unable to explore. Since start-up firms have little or no adequate cash flow to support debt obligations, then venture capital becomes appropriate. High quality information on their activities as required by traditional financiers and their prospects may be impossible or very costly to obtain externally and their level of capitalization is very low (Sagari, 1992).

2.9.0 Managed Health Care

A managed health care plan is a program that integrates the financing and delivery of health care services and promises to meet all the medical needs of its members for a set premium per month. While managed health care plans are most widely developed in the United States, they are increasingly being seen as partial solutions to health care problems in other countries (Stover, 1996). Most employers establish an annual allowance for health care services per employee, which can vary widely for classes of employees and which can be used to cover inpatient care at non-government hospitals

and in some cases outpatient and pharmacy services. Some employers seek to finance care by purchasing health care coverage from insurance companies, which assume responsibility for processing claims. Due to escalating costs and high levels of fraud and abuse, many insurers have found health care coverage unprofitable and have exited the health insurance market (Stover, 1996).

Demand for services through the government system has far outstripped the resources available and has caused patients to seek care at non-government facilities. However, the fees for private medical services often exceed an individual's ability to pay. Employers contend that the costs and problems of the health system require more concerted and sophisticated effort than they can bring to bear. They are seeking managed inpatient and outpatient health care programs, with efficient cost and fraud controls. All of these developments create both a need and an opportunity for the development and introduction of managed care plans into the market. A knowledgeable and careful sponsor has the potential to build a cost effective and successful business (Stover, 1996).

2.10.0 A Brief History of Managed Care

Managed health care can be defined as the health service that is run on business principles with the objective of making services cost effective. The main objectives of such services are to reduce cost and increase the number of people served per unit cost. Managed care trace its history to a series of alternative healthcare arrangements that appeared in various communities as early as the 19th century. The goal of these arrangements was to help meet the healthcare needs of selected groups of people, including rural residents, workers and their families. The enrollees paid a set fee to

physicians who then delivered care under the terms of their agreement. In urban areas, such groups often were paid by benevolent societies to provide care to their members.

These prepaid group practices were a model for later entities that came to be known as health maintenance organisations (HMO). Several other prepaid group practice plans developed in the 1930s and 1940s and became precursors to the modern HMO. These early prepaid group practice plans, or medical service plans, differed in their corporate structures. However they all shared a commitment to comprehensive and coordinated healthcare. In fact, their premiums were as expensive or more expensive than other insurance, but their coverage and benefits were superior, including a major emphasis on preventive care, outpatient care, well-child care services, immunizations, and other services not covered by other insurance. Members were subject to relatively few exclusions and limits.

Group practice plans, especially if they owned hospitals, could create an environment and incentives for physicians that reinforced cost-effective and high quality care. In some locations prepaid group practice plans were quite successful at attracting members. Prepaid health care remained a minor phenomenon until the 1970s phrase health maintenance organization to refer to prepaid health plans that enrolled members and arranged for their care from a designated provider network. While the initial growth and enrollment goals have not been met, managed care, as it has come to be called, has continued to grow. Employers came to look upon managed care as a less expensive yet comprehensive and high quality form of insurance to offer their employees.

2.11.0 Description of a Managed Health Care Plan

A managed health care plan incorporates a number of principles related to financing and managing the delivery of health care services that is;

- Coverage is provided for a broad range of health care services. Typically, a program will cover preventive and curative services, including inpatient and outpatient care.
- Services are generally available through a pre-selected network of providers who are under contract to the sponsor.
- The program generally provides services for a pre-determined price per member per month.
- The patient may be required to follow certain protocols to obtain care. For example, to always see a particular primary care provider who would authorize all covered specialist care.
- The sponsor will systematically and actively manage the care delivered to assure high quality.
- The program may require that the providers' share in the financial risk associated with the program.

To offer coverage for a broad range of health services at an affordable price, a managed health care plan must incorporate the perspectives and interests of the members, providers and insurers. Managed care programs use one of two organizational models;

(i) The closed-panel model, the program directly employs the health care providers who provide services to the program members. Those providers generally are located in

centralized clinic settings but the program may operate clinics at multiple sites. In some cases, the program may also own a hospital or a nursing home.

(ii) Open-panel program, medical services are provided by independent practitioners in the community who are under contract to the program. These doctors and hospitals are not employed or owned by the program.

According to integrated Health Care Association (IHA, 1997) Managed health care is a multi-faceted system for providing high quality health care while containing costs. Health Management Organizations do not all look alike, in fact, a broad array of health insurers, medical groups, hospitals and health systems are considered managed care organizations.

A managed care organization may be a physician group, health plan, hospital or any organization that is accountable for the health of an enrolled group of people. Managed care is a belief that a health care system should work to keep people healthy and when they are sick or injured, should work to assure the right treatment in the right setting by the right person. Health Management Organisations exist in different forms, with different benefit structures, financing mechanisms and provider configurations. It is still evolving and therefore very much a work in progress (IHA, 1997).

2.12.0 Attitudes

Attitudes are the stands a person takes about objects, people, groups, and issues. Attitude is the sum total of a man's inclinations and feelings, prejudice and bias, preconceived notions, ideas, fears, threats, and convictions about any specified topic. Attitude is the extent of liking or disliking something (Meuller, 1986).

2.13.0 Theories of Attitudes

2.13.1 Cognitive Dissonance Theory

The theory focuses on situations where two cognitive elements are inconsistent with one another. A cognitive element can be something a person believes about himself, a behavior he performs or an observation about surroundings. For example the two cognitive elements I know smoking cigarettes causes cancer and I smoke cigarettes are dissonant with one another. This psychological inconsistency creates a feeling of discomfort that the smoker is motivated to reduce (Assael, 1981).

The magnitude of dissonance depends upon the importance and number of dissonance elements. Dissonance reduction can occur either by eliminating, adding or changing elements. For example, the person could stop smoking or remember a great aunt, who smoked until the day she died at age 90. Alternatively, he might question the research that links cancer and smoking perhaps by believing industry sponsored studies that try to refute his connection (Assael, 1981).

2.13.2 Self – Perception Theory

Self–Perception Theory assumes that people use observations of their own behavior to determine what their attitudes are just as we assume that we know the attitudes of others by watching what they do. The theory states that we maintain consistency by inferring that we must have a positive attitude toward an object if we have bought or consumed it. Thus Nancy might say to herself I guess I must like this brand of Vodka I seem to order it a lot. Self-perception theory is relevant to the low involvement hierarchy. Since it involves situations in which behaviors are initially performed in the absence of a strong

internal attitude after the fact the cognitive and effective components of attitude fall into line. Thus buying a product out of habit may result in a positive attitude toward it after the fact- namely, why would I buy it if I didn't like it? (Calder and Ross, 1973).

2.13.3 Social Judgement Theory

Social Judgement theory assumes that people assimilate new information about attitude objects in light of what they already know or feel. The initial attitude acts as a frame of reference and new information is categorized in terms of existing standards. Just as our decision that a box is heavy depends in part on other boxes we have lifted, we develop a subjective standard when making judgments about attitude objects (Fishben, 1980).

One important aspect of the theory is the notion that people differ in terms of the information they will find acceptable or unacceptable. They form latitudes of acceptance and rejection around an attitude standard. Ideas that fall within a latitude will favorably be received while those falling outside of this zone will not. Messages that fall within the latitude of acceptance tend to be seen as more consistent with one's position than they actually are. This process is called an assimilation effect. On the other hand, messages falling in the latitude of rejection tend to be seen as even farther from ones position than they actually are resulting in a contrast effect (Fishben, 1980).

2.13.4 Balance Theory

Balance Theory considers relations among elements a person might perceive as belonging together. This perspective involves relations among three elements, so the resulting attitude structures are called triads. Each triad contains

- A person and his or her perceptions,
- An attitude object,

- Some other person or object.

These perceptions can be either positive or negative. People alter these perceptions in order to make relations among them consistent (Halloran, 1967).

The theory specifies that people desire relations among elements in a triad to be harmonious, or balanced. If they are not, a state of tension will result until somehow perceptions are changed and balance is restored. Elements can be perceived as going together in one of two ways. They can have either a unit relation, where one element is seen as somehow belonging to or being a part of the other or a sentiment relation, where the two elements are linked because one has expressed a preference or dislike for the other. A dating couple might be seen as having a positive sentiment relation upon getting married, they will have a positive unit relation. The process of divorce is an attempt to sever a unit relation (Halloran, 1967).

2.13.5 Congruity Theory

Congruity Theory specifically addresses how attitudes are affected when a person is linked to an object. Assuming that we can measure the appeal of an endorser and the favourability of a product, congruity theory can help to answer two questions regarding the effectiveness of this strategy.

- How big a boost would a product get by being paired with the endorser?
- How will the endorser's reputation be affected by his or her connection with the product?

Congruity theory predicts that the value of the more negatively valued element will rise when linked to a positively valued one. Such a popular personality, in addition, though the positively valued element will be affected, its rating will be diminished by its

association with the first element. The implication here is that a person or organization that is linked to some other entity does so at some risk. This process helps to explain why some media outlets are careful to select advertisers whose images are congruent with their own (Kiesler, 1969).

2.14.0 Attitude Measurement

Louis Thurstone is the Social Psychologist who first created attitude-measurement methodology. Thurstone method involved defining and identifying the object, then making a pool of opinion statements, some positive, some negative, some neutral (Mueller, 1986). Thurstone developed 3 scales for measuring attitude;

- Paired Comparisons

This method requires that attitude comparisons be paired in every possible combination. Since 20 statements will result in the judging of 190 pairs, this method is a lot of work.

- Equal-Appearing Intervals.

Judges sort statements one at a time on a range of extremely favorable to extremely unfavorable. It is much like Likert scaling, but neutral items are required to incorporate the entire spectrum of attitude about an object.

- Successive intervals.

This is an extension to the equal-appearing interval scaling. It tries to statistically place items on a continuum instead of relying on subjective answers given by judges. It uses the number of times different judges rate a statement to develop the rank order for the scales (Mueller, 1986). Likert stressed that when trying to measure attitude for something, it is easier to measure for tangible objects than for abstract objects. If we want

to measure abstract objects, we must define them clearly so the researcher and the subject will have the same object in mind (Mueller, 1986).

Likert believed in constructing multiple scales, or narrowly defining scales so that other dimensions wouldn't be included. He generated an item pool which included statements about beliefs for the object in question. Each item was clearly positive or negative. Likert did not use neutral statements. Most surveys use five scales ranging from strongly agree to strongly disagree (Mueller, 1986).

Louis Guttman developed a scale much like Likert and Thurstone, but he placed extreme stress on unidimensionality of the scale. He believed that if a person agreed with an all inclusive category, they should also agree with the varying parts of the category. An example follows:

- Abortion is acceptable under any circumstances.
- Abortion is acceptable in cases of rape.

If a person agrees with number one, they will agree with number two also. When judging criteria, he only used items that every judge agreed on the order of. Respondents must agree with all questions similar to one another (Mueller, 1986).

CHAPTER III

3.0 RESEARCH DESIGN

3.1.0 Population

The population of the study consisted of fourteen private for-profit Health Management Organisations as shown in (Appendix III). All the fourteen (14) firms are based in Nairobi. However some of the firms have branches outside Nairobi.

3.2.0 Data Collection

Primary data was collected by both direct interview and or drop-and-pick later method using a structured questionnaire. The researcher personally visited the firms. Follow up was done by personal visits and telephone calls to the firms. Four firms Representing 40% of the firms filled the questionnaire with the aid of the researcher while the other six (60%) filled the questionnaire without the aid of the researcher.

The major problem encountered by the researcher in data collection was the failure of respondents to keep appointments siting lack of time due to pressure of work. Others required a lot of convincing that the information sought was for academic purposes only and would not be availed to competitors. Four firms of the total target population refused to fill the questionnaire because they said the information sought was confidential particularly information touching on sources of finance and the amount of

annual turnover. The whole process of distributing and picking filled questionnaires took one and a half months between mid June and end of July 2002.

The questionnaire is shown in appendix (II) and has five sections as follows:

- Section I General information about the firms.
- Section II Sources of finance.
- Section III Venture capital awareness and use.
- Section IV Attitudes towards Venture capital and its benefits.
- Section V Venture capitalists concerns and investment criteria.
- Section VI Venture capital in Kenya and its problems.

The questionnaire was addressed to the firms' finance managers and accountants accompanied by a letter of introduction.

3.3.0 Data Analysis

Data was tabulated and statistically analysed using descriptive statistics. The purpose of descriptive statistics was to enable the researcher to meaningfully describe a distribution of scores or measurement using a few indices or statistics. This is because the study is descriptive and exploratory in nature. To achieve the objectives of the study, data was analyzed through the use of percentages, mean and standard deviation of the various parameters tested. The results are presented using tables.

$$\text{Mean} = \frac{\Sigma x}{n} \qquad \text{Standard deviation } \delta = \sqrt{\frac{\Sigma (x - \mu)}{n}}$$

n = number of values μ = population mean x = score

CHAPTER IV

4.0 DATA ANALYSIS AND FINDINGS

4.1 Population Characteristics

Fourteen questionnaires were distributed and ten were received, giving a 71% response.

All the ten questionnaires received were used for analysis.

Table 3 shows the age profile of the firms in the population.

Table 3

Firms' Age Profile.

Years	Number of firms	Percent
1 - 3	4	40
4 - 6	1	10
7 – 9	3	30
10 and above	2	20
Total	10	100

Source: Primary Data

From the above table, majority of firms (40%) fall between 1-3 years meaning they are relatively young and fit to use venture capital because venture capitalists prefer young and growing firms.

Table 4

Classification of Ownership.

Ownership	Number of firms	Percent
Local	7	70
Joint venture	1	10
Foreign	2	20
Total	10	100

Source: Primary Data

Majority of firms (70%) are locally owned and (20%) are foreign owned with only (10%) being a joint venture between local and foreign entrepreneurs.

Table 5: shows annual turnover of the firms investigated in million of Kenya shillings.

Table 5

Annual Turnover (Millions)

Turnover Ksh (millions)	Number of firms	Percent
10 – 50	4	40
51 – 100	4	40
101 – 500	1	10
500 – 999	-	-
1000 and above	1	10
Total	10	100

Source: Primary Data.

From table 5, majority of firms (80%) have annual turnover of between 10-100 million. This shows they are relatively small and growing. Only one firm has annual turnover exceeding one billion. This indicates the health sector has a lot of potential that venture capitalists can exploit. The average turnover for the sector per annum is Ksh 180,250,000.

Table 6

Permanent Employees

Employees	Number of firms	Percent
1 – 30	5	50
31-60	3	30
61 – 90	1	10
91 and above	1	10
Total	10	100

Source: Primary Data

From table 6, most firms, (80%) have sixty or less permanent employees with 50% having thirty or less. This further shows most firms are small. The average number of permanent employees is forty five (45).

Table 7 shows the number of casual employees excluding sales executives who are paid on commission and therefore do not work wholly for the firms. Casual employees work at the premises of the firms but are not permanently employed.

Table 7

Casual Employees

Employees	Number of firms	Percent
1 – 10	4	50
11 – 20	3	37.5
21 –30	1	12.5
Total	8	100

Source: Primary Data.

Only eight firms indicated the presence of casual workers, and of the eight, 50% had ten or less causal workers. The average number of casual workers is twelve, further indicating the small size of the firms.

Table 8

Rank of Respondents

Rank	Number of firms	Percent
Accountant	6	60
Sales manager	1	10
Administrator	2	20
General manager	1	10
Total	10	100

Source: primary Data

Majority (60%)of respondents are accountants. The questionnaire was addressed to finance managers and accountants because they would be in a better position to understand issues of venture capital financing.

4.2 Sources of Finance

Respondents were asked to indicate the various sources of finance they used to start their operations. The results, as shown in table 9 indicate that majority of firms used bank loans (70%) and personal savings (60%) to start their operations. Venture capital does not feature prominently in starting a firm but 30% of the firms used it. Another type of financing that these firms use is premium financing and 20% of the firms used it.

Table 9

Sources of Finance

Sources	Number of firms	Percent
Bank loans	7	70
Personal savings	6	60
Micro-finance loans	-	-
Venture capital	3	30
Donor funds	-	-
Premium financing	2	20

Source: Primary Data

Respondents were also asked to indicate their satisfaction with the various sources of finance. Their satisfaction was rated between one to five that is extremely dissatisfied, dissatisfied, neutral, satisfied and extremely satisfied. The results are shown in table 10.

Table 10

Satisfaction With Sources of Finance

Sources	Average score	Standard deviation
Bank loans	2.8	1.32
Personal savings	3.6	0.98
Micro finance loans	3.5	0.93
Venture capital	4.5	0.53
Donor funds	3.8	1.28

Sources: Primary Data

Despite the fact that bank loans are commonly used respondents are not satisfied with it as a source of finance. They gave a mean score of 2.8 that is near neutral and a standard deviation of 1.32. The high cost of borrowing is the main cause of their dissatisfaction with bank loans. Personal savings are favoured because they do not initially come with a cost to the form. Even though micro-finance loans and donor funds were not used to start any firm, the respondents could favour them because they got a mean score of 3.5 and 3.8 respectively with a standard deviation of 0.93 and 1.28 respectively. Majority of firms showed high levels of satisfaction with venture capital, with a mean score of 4.5 and a standard deviation of 0.53. This confirms that risky sectors prefer venture capital to finance their operations.

4.3 Venture Capital Awareness and Use

Respondents were asked to tick statements that are true about venture capital financing to test their awareness. The results are presented in table 9

Table 11

Awareness of Venture Capital

Statement	Number of firms	Percent
Finance new and rapidly growing companies	10	100
Purchase equity securities	4	40
Assist in the development of new products or services	8	80
Add value to the company through active participation	5	50
Take higher risks with the expectation of higher rewards	7	70
Have a long-term investment orientation	5	50
Venture capital financing has no required rate of return	2	20

Source: Primary Data

Majority of firms indicated an awareness of venture capital. Only 20% of the respondents thought venture capital Financing has no required rate of return. All firms agreed (100%) that venture capital is used to finance new and rapidly growing

companies. Fifty (50%) per cent of the firms indicated they have used venture capital before. This confirms the health management sector as a risky sector and suitable for venture capital. Of the fifty percent (50%) firms that used venture capital, twenty percent (20%) used it in starting their operations, a hundred percent (100%) used it for expansion and sixty percent (60%) used it for restructuring. No firm has used venture capital for management buyouts (MBO). Only one firm of the five (5) that used venture capital used it very often but the others, use it moderately. It follows that venture capital can be a popular source of funding the health management organizations.

4.4 Attitudes Towards Venture Capital and Benefits

Respondents were asked to tick routes, which venture capitalists use to invest. The results are shown in table 12 below.

Table 12

Venture Capital Investment Routes

Route	Number of firms	Percent
Equity shares	10	100
Redeemable preference shares	2	20
Non-convertible debt instruments	2	20
Convertible instruments	2	20

Source: Primary Data

All respondents (100%) agreed that venture capitalists mainly invest through equity stocks in target firms. The other routes of redeemable preference shares, convertible and non-convertible debt instruments received only (20%) mention, indicating they are not popular or respondents are not familiar with these routes.

Respondents were also asked to rank their attitudes on a scale of 1-5, that is strongly disagree, disagree, neutral, agree and strongly agree, about their attitudes towards venture

capitalists. All respondents felt and agreed that venture capitalists invest only in successful and expanding businesses. The results are shown in table 13.

Table 13

Attitude Towards Venture Capitalists

Statement	Average score	Standard deviation
Insensitive to early stage projects	2.4	1.24
Bankers with little practical knowledge	2.3	0.89
Invest only in successful expanding business	4.0	1.15
Negotiations take too long	3.7	0.71
Do not meet funding needs	2.8	1.10
Valuations are unfair	3.1	0.93
Assume they know everything	2.7	1.32

Source: Primary Data.

Respondents disagreed with the statement that venture capitalists are insensitive to early stage projects and this shows venture capitalist do actually favour early stage projects. The mean score was 2.4 with a standard deviation of 1.24. They also felt venture capitalists are not bankers with little practical knowledge because they gave mean score of 2.3 with a standard deviation of 0.89. However, they felt generally negotiations take too long and this discourages the use of venture capital. They disagree that venture capitalists do not meet funding needs with a score of 2.8 and standard deviation of 1.10. They were neutral about valuations being unfair with a mean score of 3.1 and a standard deviation of 0.93. They also felt that venture capitalists do not assume they know everything and therefore the contribution of the firms themselves is important.

Table 14 shows respondent's feelings towards the benefits of venture capital on a scale of 1-5, that is extremely dissatisfied, Dissatisfied, neutral, satisfied and extremely satisfied.

Table 14

Benefits Venture Capital

Statement	Average score	Standard deviation
Risk sharing	4.0	1.15
Management experience	3.6	1.17
Businesses contacts	3.8	0.46
Marketing and Financial Planning	3.6	0.73
Manpower, planning and recruitment of personnel	3.2	1.30
Reputation to the firm	4.0	0.93
Transfer of technology	3.1	1.27

Source: Primary Data.

Most respondents were satisfied with risk sharing as a benefit with a mean score of 4 and a standard deviation of 1.15. This is true because entrepreneurs use venture capital because of the risk sharing elements. They also were positive about the benefits received from management experience, business contacts and marketing and financial planning with a mean score of 3.6, 3.8 and 3.6 respectively. However, the standard deviation varied, that is 1.17, 0.46 and 0.73 respectively. They were also satisfied with a mean score of 4 about the ability of venture capitalists to give reputations to a firm, with a standard deviation of 0.93. However, they were neutral on the ability of venture capitalists in manpower planning, recruitment of personnel and transfer of technology with a score of 3.2 and 3.1 respectively and a standard deviation of 1.3 and 1.27 respectively.

4.5 Venture Capitalists Concerns and Investment Criteria.

Respondents were asked to rank on a scale of 1 – 5 that is strongly disagree, disagree neutral, agree or strongly agree about what they thought venture capitalists look for in target firms. The results are presented in table 15.

Table 15

Concerns of Venture Capitalists in Target Firms

Statement	Average score	Standard deviation
Technical feasibility of product/service	4.6	0.70
Marketing aspects and size of the market	3.9	1.10
Adequacy of accounting systems	3.9	1.46
Government influence and regulations	3.1	1.36
Number of competitors	3.9	1.29
Export potential	3.3	1.50
Involvement of international institutions	3.4	1.01

Source: Primary Data

Most respondents strongly agree with a mean score of 4.6 and standard deviation 0.79 that technical feasibility of product or service is very important to venture capitalists. They also agree that marketing aspects and size of the market , adequacy of accounting systems and number of competitors with a mean score of 3.9 and standard deviation of 1.1, 1.46 and 1.29 respectively are also important considerations influencing venture capitalists. However, they are neutral with regard to government influence and regulations, export potential and involvement of international institutions with mean scores of 3.1,3.3 and 3.4 respectively and standard deviation of 1.36, 1.5 and 1.0.

Respondents were asked the main criteria used to identify target firms. Ninety percent (90%) believe returns from investment is the main deciding factor for venture capitalists and the stage the firm is in (80%) at the time of negotiations. The sector the target firm is in also matters with a score of 60% of all respondents. However, management (40%) and location (30%) did not seem to be key factors in influencing venture capitalists.

4.6 Venture Capital in Kenya

Majority (90%) believe foreign institutional investors are the main providers of venture capital. Fifty percent (50%) believe that multilateral financial institutions and wealthy individuals also contribute. Banks (30%), insurance companies (10%) and government development financial institutions (20%) contribute little to venture capital in Kenya. Respondents were asked to rank on scale of 1-5 problems of venture capital financing in Kenya. The results are shown on table 16.

Table 16

Problems of Venture Capital Financing in Kenya

Statement	Mean Score	Standard deviation
Lack of good business proposals	3.9	1.17
Readiness of local investors	3.7	0.87
Tax disincentives	4.2	0.92
Social approval of entrepreneurship	2,4	1.01
Government regulatory structures	3.9	1.20
Lack of information about operations of venture capital	4.5	0.71
Growth prospects	4.3	0.68
Fear of failing to meet venture capital expectations	4.1	0.88
Availability of other cheaper sources of funds	2.0	1.33

Source: Primary Data

Most respondents strongly agree that lack of information about venture capitalists is a major problem in Kenya. This implies little awareness has been created. Lack of good business proposals, readiness of local investors, tax disincentives, government regulatory structures, growth prospects and fear of failing to meet venture capital expectations are also key factors that impede the use of venture capital. However, respondents disagreed that social approval of entrepreneurship and availability of other cheaper sources of funds contributes to low use of venture capital in Kenya.

CHAPTER V

5.0 SUMMARY, LIMITATIONS AND RECOMMENDATIONS

5.1 Summary

Majority of firms' (80%) have been in existence for less than 10 years and most of them (70%) are locally owned. The annual turnover is Ksh 100 million or less for most firms (80%) with only one firm having over Ksh 1 billion in turnover. These firms are not regulated by any body and are only required to comply with requirements of the company act. However, the Association of Kenya Insurers is lobbying to have them put under the insurance Act. In the budget speech of June 2002 for the year 2002/2003 the minister of finance directed the firms to be put under the insurance Act and controlled by the commissioner of insurance but there appears to be a confusion since health Management organizations are not covered by the Act. Some health management organization also own laboratories, hospitals and chemists and this make them unique. If put under the insurance Act, this will radically affect the current and future firms because of being required to have minimum capital which is not there now.

On the basis of the low turnover (table 5) few permanent employees (table 6), and even fewer casual employees (table 7) most health management organizations are small entities operating in a rapidly growing sector. Their small size and growth potential makes them viable for venture capital investment. The main source of finance to start the firms was bank loans (80%) and personal savings (60%). However they all indicated to

be dissatisfied with bank loans as a source of finance because of the high interest it attracts. Venture capital is not greatly used (30%) to start the firms but the respondents regard it favourably. This shows venture capital can be a good source of finance for start-ups particularly in risky sectors.

The health sector is risky because of the prevalence of fraud caused by doctors and employees of HMO's. Doctors overstate patient costs and treat excluded ailments. They also treat persons not covered by the schemes.

Most respondents are aware about venture capital particularly the fact that they finance new and rapidly growing companies and assist in the development of new products or services. The health sector is growing because currently only three hundred thousand Kenyans out of a population of thirty million are covered by both the health management organizations and insurance companies. The rapid growth of this sector is because people who understand the health sector and are able to give personal attention than the other insurance companies run the firms more professionally.

Expansion and restructuring are the main reasons why these firms require venture capital financing. Fifty percent of the firms have used venture capital and the trend could go on in future. The fact that the firms receive premiums on an installment basis from members but have to pay all bills incurred at once make them risky. If accident and disease prevalence rises tremendously they incur heavy costs and this makes their return variable requiring heavy investment, thus the need for venture capital. Respondents also believe

(70%) that venture capitalists take higher risks with the expectation of higher rewards and therefore they would prefer them since their sector is risky.

Venture capitalists prefer investing through equity shares according to the respondents (100%) . This shows that , if the risk is high, and they expect high returns, they can only get the high returns through equity participation. Equity participation ensures they participate in management and other areas of the firms operations. Since respondents feel venture capitalists finance new and rapidly growing firms (100%), they therefore disagree (2.4) with the statement that venture capitalists are insensitive to early stage projects. The respondents disagree (2.3) that venture capitalists are bankers with little practical knowledge. The implication is that venture capitalists bring more than money.

Risk sharing because of variability of return is the main reason that pulls respondents to venture capital as well as the ability of venture capitalists to give the firms a good reputation. However most respondents do not believe venture capitalists transfer technology to them. Respondents also strongly agree that the technical feasibility of products or service is very important to venture capitalists. The health management sector is a new concept with huge potential because the untapped market is still large. The number of competitors, according to respondents is also important to venture capitalists while choosing a target firm but government influence and regulations are not very critical. However, in general, a return from a sector is the other main factor that influences investment decisions of a venture capitalists.

The Kenya venture capital market is dominated by foreign institutional investors according to respondents (90%) but the main deterrent to its continued use generally is the lack of information about operations of venture capital. This means that the existing venture capitalists have not created enough awareness about their products nor have they captured all segments of the economy. The respondents do not think there exists any other cheaper source of finance other than what they are using, that is bank loans and personal savings that could hinder the use of venture capital. This means with proper mobilization venture capital can be a major source of financing for Kenyan firms.

The respondents feel that with adequate financing they can provide affordable, cheap and comprehensive medical cover to all Kenyans. Since the health management sector is yet to be fully developed, has a high growth potential and Kenyans demand for good and affordable health is growing continuously and coupled with reduced government intervention in the health sector then venture capitalists should find this sector appropriate for their investment purposes.

5.2 Limitations

In the course of the research the following three major problems were encountered by the researcher;

- The lack of a regulatory body for the health management firms made it difficult to ascertain beyond reasonable doubt that all HMO's were covered in the study. Efforts to get a list from the ministries of health and finance proved unsuccessful. These left the researcher to rely on the known HMO's to identify other players in the sector.

- The other problem was lack of information regarding the operations of HMO's in Kenya. Neither the ministry of health nor that of finance clearly understand the HMO sector. These was evidenced by the clear lack of documented data with regard to the same. Even the association of insurers does not have information about this sector.
- Information regarding the venture capital sector is also scanty. It is also a sector that has not been covered extensively by researchers and other scholars. The information available is with regard to foreign countries. Unlike in many countries where there is a venture capital association, that is not the case in Kenya. This made information gathering difficult.

Other limitations to the study included;

The health sector in Kenya has many players including the government, non-governmental organizations (NGO'S), missionaries, the private hospitals, insurance companies and the health management firms among others. The many players make it difficult to rely on the conclusion that one sector can fully address the health problems of all Kenyans. Since health management firms are not regulated as at the time of undertaking this study, then if they are put under the insurance Act, the conclusions might be different in an environment where there exists government regulations.

Since only 60% of the respondents are in finance sections of the firms analyzed, the other 40% is difficult to say whether they fully understand issues concerning venture capital.

-It was difficult to separate those firms that operate their own hospitals and chemists and those that rely on other established hospitals and chemists. Since no secondary evidence

like annual reports was provided to the researcher, it is difficult to confirm the figures given by firms for annual turnover and number of employees both permanent and causal.

5.3 Recommendations for Future Research

The researcher recommends the following areas for further research;

A similar study can be carried out to include all firms and institutions dealing with health care provision. This would show whether the different health care providers perceive venture capital the same way the health management firms do.

Since the government has intentions of regulating the health management firms by putting them under the commissioner of insurance and the insurance Act, a study can be done after implementation to see what effect this change could have on the firms.

A study can also be carried out to determine if those firms that use venture capital perform better than those that do not use venture capital.

EPILOGUE

"*Now all has been heard;*
Here is the conclusion of the matter: Fear God and keep His commandments, for this is the whole duty of man. For God will bring every deed into judgement, including every hidden thing whether it is good or evil." Ecclesiastes 12:13-14.

The Holy Bible, New International Version.

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APPENDICES

APPENDIX I

LETTER OF INTRODUCTION TO THE RESPONDENTS

CARLO CHEGE

UNIVERSITY OF NAIROBI

P O BOX 30197 NAIROBI

Dear Sir/Madam,

I am a master's student in the faculty of commerce Nairobi University. In partial fulfillment of the requirements of the degree of Master of Business Administration (MBA), I am conducting a study entitled **"AN INVESTIGATION INTO THE USE OF VENTURE CAPITAL BY PRIVATE FOR-PROFIT MANAGED HEALTH CARE FIRMS (HMO's) IN KENYA."**

Your firm has been selected to form part of the study. I kindly seek your assistance in completing the attached questionnaire. Any information that you provide to make this study a success will be highly appreciated. The information and data required is needed for academic purposes only and will be treated with strict confidence. A copy of the study results will be availed to you on request. Your cooperation in participating in this study will be highly appreciated.

Yours sincerely,

Signed:_____ Signed:_____

Carlo Chege (MBA –student) Barasa J. L. (Supervisor)

APPENDIX II

QUESTIONNAIRE

SECTION I GENERAL INFORMATION

(i) Name of the firm _____.

(ii) Company age profile (years). Please put a tick ☐ in the box next to the right response.

- ☐ Less than 1 year
- ☐ 1 – 3 years
- ☐ 3 – 5 years
- ☐ More than 10 years

(iii) Classification of ownership of company.

- ☐ Local
- ☐ Joint venture (Local and Foreign)
- ☐ Foreign
- ☐ Others (specify) _____

_____

(iv) Annual turnover in Ksh._____

(v) Number of employees
a) Permanent _____
b) Casual _____

(vi) Rank of respondent _____

SECTION II SOURCES OF FINANCE

i) The following are the various sources of finance for a business, please tick only those that describe your sources of finance;

- Bank loans ☐
- Personal savings ☐
- Micro-finance loans ☐
- Venture capital ☐
- Donor funds ☐
- Others (specify)

_____

_____

(ii) Please circle the number that best describes your satisfaction with the above sources of finance;

key; 1= extremely dissatisfied 2= dissatisfied
3= neutral 4= satisfied
5= extremely satisfied

Bank loans	1	2	3	4	5
• Personal savings	1	2	3	4	5
• Micro-finance loans	1	2	3	4	5
• Venture capital	1	2	3	4	5
• Donor funds	1	2	3	4	5

SECTION III VENTURE CAPITAL AWARENESS AND USE

(i) Please tick only those statements that are true about venture capital financing.

- Finance new and rapidly growing companies ☐
- Purchase equity securities ☐
- Assist in the development of new products or services ☐
- Add value to the company through active participation. ☐
- Take higher risks with the expectation of higher rewards. ☐
- Have a long-term investment orientation ☐
- Venture capital financing has no required rate of return ☐

(ii) Has your firm used venture capital before?

Yes ☐ No ☐

(iii) If yes, at what stage did you use venture capital?

- Starting the firm ☐
- Expanding the firm ☐
- Management Buyout (MBO) ☐
- Restructuring the firm ☐
- Others, (specify) _____

(iv) From the following statement, which one describes the extent of your use of venture capital?

- Very Oftenly ☐
- Quite a bit ☐
- Moderately ☐
- Never ☐

SECTION IV ATTITUDES TOWARDS VENTURE CAPITAL AND THEIR BENEFITS

(i) Venture capitalists invest using the following routes. State the ones you are familiar with by ticking ☐

- Equity shares ( )
- Redeemable preference shares ( )
- Non-convertible debt instruments ( )
- Convertible instrument ( )
- Others (specify):

_____

(ii) Please circle the number that describes your feelings about venture capitalists attitudes

Key; 1 = Strongly disagree 2 = Disagree 3 = Neutral
4 = Agree 5 = Strongly agree

• Insensitive to early stage projects	1	2	3	4	5
• Bankers with little practical knowledge	1	2	3	4	5
• Invest only in successful expanding business	1	2	3	4	5
• Negotiations take too long	1	2	3	4	5
• Do not meet funding needs	1	2	3	4	5
• Valuations are unfair	1	2	3	4	5
• Assume they know everything	1	2	3	4	5

(iii) Please circle the number that best describes your feelings about the benefits of venture capital.

Key;
1 = Extremely dissatisfied 2 = Dissatisfied
3 = Neutral 4 = Satisfied
5 = Extremely satisfied.

• Risk sharing	1	2	3	4	5
• Management experience	1	2	3	4	5
• Business contacts	1	2	3	4	5
• Marketing and Financial planning	1	2	3	4	5
• Reputation to the firm	1	2	3	4	5

• Manpower planning and recruitment of Personnel	1	2	3	4	5
• Transfer of technology	1	2	3	4	5

SECTION V VENTURE CAPITAL CONCERNS AND INVESTMENT CRITERIA

(i) Please circle the number that best describes your feelings about the concerns of venture capitalists in target firms.

Key;

1 = Strongly disagree 2 = Disagree 3 = Neutral
4 = Agree 5 = Strongly agree

• Technical feasibility of product/service	1	2	3	4	5
• Marketing aspects and size of the market	1	2	3	4	5
• Adequacy of accounting systems	1	2	3	4	5
• Government influence and regulations	1	2	3	4	5
• Number of competitors	1	2	3	4	5
• Export potential	1	2	3	4	5
• Involvement of international institutions	1	2	3	4	5

(ii) From the following categories, please tick (✓) the ones that best describe venture capitalists investment criteria.

- Management ( )
- Sector ( )
- Stage of the firm ( )
- Returns ( )
- Location ( )

SECTION VI VENTURE CAPITAL IN KENYA

(i) Please select by ticking (✓) who are the providers of venture capital in Kenya?

- Foreign institutional investors ( )
- Multilateral development finance institutions ( )
- Banks ( )
- Insurance companies ( )
- Government development financial institutions ( )
- Wealthy individuals ( )

- Others (specify) _____

(ii) Please circle the number that best describes your feelings about problems of venture capital financing in Kenya.

Key;

1 = Strongly disagree 2 = Disagree 3 = Neutral
4 = Agree 5 = Strongly agree

• Lack of good business proposals	1	2	3	4	5
• Readiness of local investors	1	2	3	4	5
• Tax disincentives	1	2	3	4	5
• Social approval of entrepreneurship	1	2	3	4	5
• Government regulatory structures	1	2	3	4	5
• Lack of information about operations of Venture capital	1	2	3	4	5
• Growth prospects	1	2	3	4	5
• Fear of failing to meet venture capital expectations	1	2	3	4	5
• Availability of other cheaper sources of funds	1	2	3	4	5
• Other (specify _____					

In the spaces provided below, kindly put any comments regarding venture capital financing in Kenya and in particular to managed health care firms.

_____

_____

_____

_____

_____

_____

Thank you for your participation and cooperation.

APPENDIX III

HEALTH MANGEMENT ORGANISATIONS (HMO'S) IN KENYA

1. AAR Health Services.
2. Avenue Health Care.
3. Health First International (K)
4. Health Management Solutions Ltd.
5. Health Plan Services Ltd.
6. Health Risk Management Ltd.
7. Integry Health
8. Medical Express Kenya ltd
9. Medical Partners ltd
10. Medifort Services ltd.
11. Mediguard Ltd.
12. Mediplus Services Ltd.
13. Mesco Consultants ltd.
14. Strategies Health

Source: Kenya Association of Heath Care Organizations (KAHO), June 2003

APPENDIX IV

LIST OF INSURANCE FIRMS

1. African Merchant Assurance Company Limited
2. American Life Insurance Company (K) Limited
3. Apollo Insurance Company Limited
4. Blue Shield Insurance Company Limited
5. British American Insurance Company Limited
6. Cannon Assurance Company Limited
7. Concord Insurance Company Limited
8. Co-operative Insurance Company Limited
9. Corporate Insurance Company Limited
10. East Africa Reinsurance Company Limited
11. Fidelity Insurance Company Limited
12. First Assurance Company
13. Gateway Insurance Company Limited
14. Geminia Insurance Company Limited
15. General Accident Insurance Company Limited
16. Heritage All Insurance Company Limited
17. Intra Africa Assurance Company Limited
18. Insurance Company of East Africa Limited
19. Invesco Assurance Company Limited
20. Jubilee Insurance Company Limited
21. Kenindia Assurance Company Limited
22. Kenya National Assurance (2001) Company Limited
23. Kenya Orient Insurance Company Limited
24. Kenya Reinsurance Corporation Limited
25. Kenya Alliance Insurance Company Limited
26. Liberty Assurance Company Limited
27. Lion of Kenya Insurance Company Limited
28. Madison Insurance Company Limited
29. Mercantile life and General Assurance Company Limited
30. Occidental Insurance Company Limited
31. Old Mutual Life Assurance Company Limited
32. Pan Africa Insurance Company Limited
33. Phoenix East Africa Assurance Company Limited
34. Pioneer Assurance Company Limited
35. Royal Insurance Company Limited
36. Standard Assurance Company Limited

37. Tausi Assurance Company Limited
38. The Monarch Insurance Company Limited
39. Trident Insurance Company Limited
40. Trinity Life Assurance Company Limited
41. UAP Provincial Insurance Company Limited
42. United Insurance Company Limited

Source: Commissioner of Insurance, Kenya December 2002.

APPENDIX V

LIST OF VENTURE CAPITAL FIRMS IN KENYA

1. Acacia Fund.
2. Africa Magic Fund
3. African Project Development Facility.
4. Aureos E. A Fund.
5. East African Development Bank (EADB).
6. Economic Development for Equatorial and Southern Africa.
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