

Financial Viability of Private Health Care Facilities in Urban Areas: Case Study of the Bandalungwa Health District, Kinshasa, Democratic Republic of the Congo

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ABSTRACT

Introduction

The financial viability of healthcare facilities in the Democratic Republic of Congo (DRC) depends heavily on their ability to cover expenses through self-generated revenues. While the private sector plays a vital role in healthcare delivery in urban areas, it remains costly and largely inaccessible to poor households. Due to self-financing constraints, facilities struggle to meet operating costs, often driving price increases that further restrict access. Despite their growing market share, empirical data on their financial sustainability are sparse, highlighting the critical need to assess their profitability.

Purpose

To analyze the financial viability of private, for-profit health care establishments (HCEs) in the Bandalungwa health district.

Methods

This study used a mixed-methods case study design involving 11 HCEs in the Bandalungwa health district of Kinshasa. The study population comprised private, for-profit HCEs operating between January and December 2022. Data were gathered through semi-structured interviews, document reviews, and non-participant observations. Quantitative data were analyzed using descriptive statistics in SPSS 27. Qualitative data were analyzed using a thematic framework matrix in Microsoft Excel to identify primary and secondary operational patterns.

Results

Small enterprises dominated the private, for-profit healthcare landscape in the district (91%). Overall staff stability was low (27.3%), and the majority of HCEs (82%) were managed directly by their owners. Most facilities (82%) successfully covered their operational expenses through self-generated revenue and achieved positive net profits. Direct, out-of-pocket payments from households were the predominant source of funding.

Conclusion

While most private HCEs in Bandalungwa demonstrate financial viability, their reliance on direct fee-for-service payments leaves them highly vulnerable to local economic shocks. This fragile model severely restricts healthcare access for low-income populations, emphasizing the urgent need for universal risk-pooling and alternative financing mechanisms.

INTRODUCTION

The financial viability of a healthcare facility depends on its structural capacity to cover its operational expenditures through self-generated revenues and external funding streams (Hussien et al., 2022). In the Democratic Republic of Congo (DRC), this financial equilibrium is a critical issue, particularly for private facilities that operate almost exclusively on a self-financing basis. The public health system in the DRC is organized around the primary healthcare model established by the Alma-Ata Declaration. However, these standards were designed primarily for rural settings. When applied to rapidly expanding urban centers, they fail to address urban complexities, such as the epidemiological transition toward chronic non-communicable diseases and the elevated expectations of an urbanized population (Fina-Lubaki et al., 2024; Nyamugira et al., 2022; World Health Organization [WHO], 2010).

A substantial portion of healthcare costs in the DRC is borne directly by households, excluding a significant segment of the population from formal care due to underdeveloped insurance and social protection networks (Shapira et al., 2023). Furthermore, the country faces systemic challenges, including widespread poverty, stark rural-urban inequalities, a massive informal economic sector, and damaged infrastructure. Rapid urbanization exacerbates these pressures, causing a rise in both infectious and non-communicable disease burdens (Organisation mondiale de la santé [OMS], 1994).

Healthcare is delivered by a mix of public and private providers. The private sector is highly developed in urban areas, accounting for a significant share of outpatient, inpatient, and surgical care. However, access remains limited for low-income households (Kambamba, 2013). Private health care establishments (HCEs), which frequently rent premises and face high overhead costs, depend heavily on direct patient payments. Their revenues are often volatile and insufficient to comfortably cover operating costs, leading to high staff turnover, a lack of formal employment contracts, and escalating medical fees. This cost inflation further compromises the affordability of care and lowers patient satisfaction (Dijkzeul & Lynch, 2006).

Despite the growing market share of the private healthcare sector, there is little empirical research on its financial viability as micro, small, and medium-sized enterprises. Given the high demand for healthcare services and high unemployment rates among health professionals, analyzing the financial dynamics of private, for-profit facilities is essential.

This study analyzed the financial viability of private, for-profit HCEs in the Bandalungwa health district from January to December 2022, and identified the primary organizational and managerial factors associated with their financial performance.

METHODS

Study Design and Setting

This study utilized a mixed-methods (quantitative and qualitative) case study design. It was conducted in the Bandalungwa health district, located within the city-province of Kinshasa. This area was selected due to its high concentration of private healthcare facilities (95% of total local providers) and its socio-economic environment, which is heavily dominated by the informal sector. The health district covers an area of 6.82 km², has an estimated population of 190,540 inhabitants, and is subdivided into eight health areas. At the time of the study, there were 45 functional healthcare facilities in the district, 42 of which were private and for-profit.

Study Population and Sampling

The study population comprised all private, for-profit HCEs that operated continuously between January and December 2022.

To be included in the study, facilities had to meet the following criteria:

1. Integrated into the Bandalungwa health district administrative network for at least three years prior to the study.
2. Fully operational during the entire 12-month study period (January–December 2022).
3. Obtained formal, written consent from the administrative director or owner to participate.

Sampling Strategy

A two-stage sampling design was used to select a convenience sample of 11 HCEs:

- A. **Stage 1:** Six of the eight health areas (clusters) in the district were selected using simple random sampling.
- B. **Stage 2:** Within each selected health area, two HCEs were selected using simple random sampling, except in one health area where only one facility met the inclusion criteria, yielding a final sample size of $N = 11$.

Variables

- **Dependent Variable:** Financial viability of the HCE (defined as the ability to generate positive net annual profit and maintain self-financing autonomy).
- **Independent Variables:** Number of employees/staff, tax-exclusive turnover, financial autonomy, annual net profit, management profile (owner vs. hired administrator), physical infrastructure condition, bed capacity, room capacity, average length of stay (ALOS), geographic accessibility, local competition, drug markups, personnel costs, medical supply costs, general operating overhead, depreciation charges, pricing structures, and sources of funding.

Data Collection Techniques and Quality Assurance

Three complementary data collection techniques were used:

- a) **Semi-structured Interviews:** Conducted with HCE managers and administrative staff (including founders, medical directors, nursing directors, and financial managers). The interviews used a pre-tested guide focused on operational costs, revenue streams, and managerial decision-making.
- b) **Document Review:** Financial data were extracted from cash books, patient registers, and annual financial statements to verify operating revenues and expenditures.
- c) **Non-participant Observation:** Conducted using structured checklists to evaluate physical

infrastructure quality, equipment maintenance, and overall clinical workflows.

Interviews were audio-recorded with participant consent and transcribed verbatim. Field notes documenting participant non-verbal behaviors and environmental factors were integrated into the transcripts.

Data Analysis

Quantitative data were cleaned, coded, and analyzed using SPSS Version 27. Descriptive statistics, including frequencies and percentages, were calculated for all nominal and categorical variables.

Qualitative transcripts underwent thematic analysis. A coding guide was developed using deductive codes from the literature alongside inductive codes from the transcripts. Code mapping was performed line-by-line in Microsoft Excel 2016. A thematic matrix was constructed to cross-reference codes across different categories of participants and identify majority and minority thematic trends.

Ethical Considerations

The study was approved by the Institutional Review Board of the Kinshasa School of Public Health (Approval No. [ESP/CE/0738/2024](#)). Administrative clearance was obtained from provincial health authorities. Written informed consent was secured from all participating managers and administrators. Data confidentiality and anonymity were maintained by replacing facility and participant names with alphanumeric codes.

RESULTS

Structural and Human Resource Characteristics

Figure 1 outlines the structural taxonomy of the studied private HCEs.

Figure 1:
Distribution of Private For-Profit HCEs by Enterprise Size (N = 11)



The results show a clear predominance of small enterprises among the private HCEs in Bandalungwa, with 91% classified as small based on their total staff size. Staff stability was low across the sample: only 27.3% of small HCEs maintained a stable clinical workforce during the fiscal year 2022, while medium-sized enterprises reported 0% stability.

In terms of annual turnover, the distribution was heterogeneous: 45.5% of the facilities operated as small business entities, 36.4% as micro-scale structures, and 18.2% fell within the medium-enterprise revenue threshold.

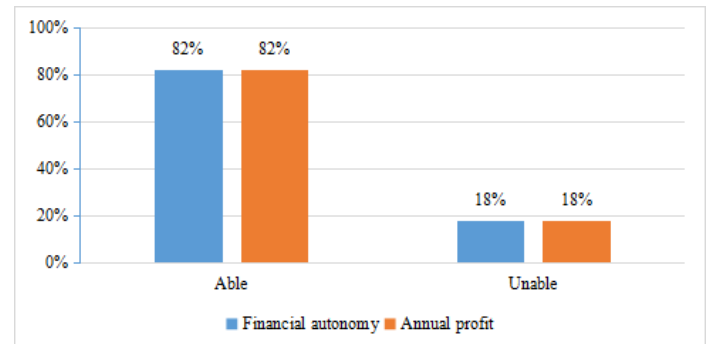
Table 1:
Organizational and Managerial Characteristics of Private HCEs (N = 11)

Variable	Sub-variable	Frequency (n)	Percentage (%)
Administrator Profile	Owner-Operator	9	81.8
	Hired Administrator / Other	2	18.2
Building Condition	Attractive / Well-maintained	8	72.7
	Less attractive / Poorly maintained	3	27.3
Inpatient Bed Capacity	Moderate-to-high capacity	7	63.6
	Limited capacity	3	27.3
	Highly restricted capacity	1	9.1
Geographical Accessibility	Easy road/pedestrian access	11	100.0
Pricing Methodology	Direct Fee-for-Service (Out-of-Pocket)	9	81.8
	Combined Copay (Insurance & Out-of-Pocket)	1	9.1
	Flat-rate / Capitation Fee	1	9.1
Staff Compensation Costs	Moderate	7	63.6
	Low	1	9.1
	High	2	18.2
	Unspecified / No Data	1	9.1
Medical Supply Expenditures	Moderate	4	36.4
	Low	4	36.4
	High	2	18.2
	Negligible / None	1	9.1
General Operating Overhead	High	1	9.1
	Moderate	4	36.4
	Low	5	45.5
	Very Low	1	9.1
Equipment Maintenance/Reinvestment	High Reinvestment	4	36.4
	Low/Negligible Reinvestment	7	63.6

Financial Viability and Solvency

Figure 2 shows the self-financing capacities and net profit margins of the studied HCEs.

Figure 2:
Financial Viability Metrics of Studied HCEs (N = 11)



Most private HCEs (82%) covered their operational expenses using their own revenue, while 18% reported a persistent deficit. Similarly, 82% of the sampled facilities recorded positive net annual profits, though a portion of these profits was marginal.

Organizational and Managerial Profiling

Table 1 describes the core organizational and managerial profiles of the HCEs.

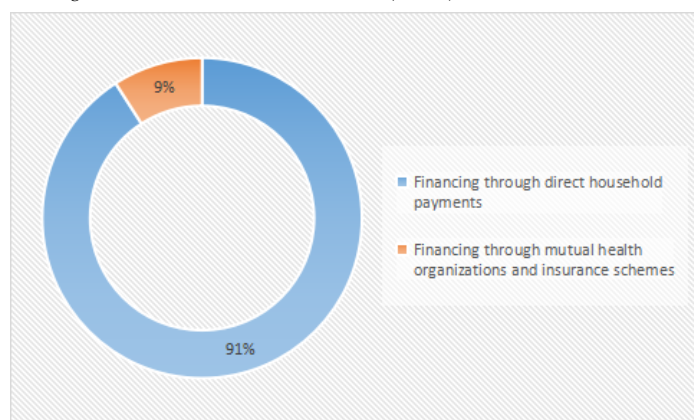
The majority of facilities (81.8%) were managed directly by their owners. While physical infrastructure was generally rated as attractive (72.7%), inpatient capacity was uneven, with 63.6% exhibiting moderate-to-high bed capacity. Every studied facility (100%) had good geographical accessibility.

Financially, pricing models relied heavily on transaction-based, fee-for-service mechanisms (81.8%). Operational cost-containment measures were common: 63.6% of the facilities kept staff compensation costs moderate, and 63.6% spent very little on equipment maintenance or capital reinvestment.

Financing Channels

Figure 3 outlines the distribution of funding sources across the surveyed HCEs.

Figure 3:
Funding Source Distribution in Private HCEs (N = 11)



Direct out-of-pocket household payments were the primary source of operational funding for the HCEs (85%), followed by informal or alternative funding mechanisms (12%). Prepayment schemes, mutual funds, and private commercial insurance plans made up only 3% of total revenues.

DISCUSSION

This study analyzed the financial viability of private, for-profit HCEs in the Bandalungwa health district of Kinshasa to understand how these micro, small, and medium-sized healthcare enterprises maintain financial sustainability.

Structural Framework and Financial Viability

The high concentration of small enterprises (91%) in the private healthcare sector confirms that local providers function primarily as small business entities. These facilities prioritize immediate financial solvency to survive, aligning with findings by [Kholi and Wanjiru \(2013\)](#) on private-sector healthcare delivery across Sub-Saharan Africa.

The high rate of financial self-sufficiency (82%) and positive annual net profits suggest that these HCEs have adapted their services to meet local demand while remaining profitable. However, the finding that nearly one-fifth (18%) of these facilities cannot cover their operational costs highlights a fragile business model. As noted by [Hussien et al. \(2022\)](#) in their analysis of community-based health schemes in East Africa, factors such as adverse selection, moral hazard, delays in claim reimbursement, and low premium structures often undermine the financial health of local providers.

Managerial Practices and Infrastructure

The financial viability of these facilities is closely linked to their management structures. Direct owner-operator management (81.8%) allows for tight control over revenues and expenditures, which is vital for maintaining solvency ([Pradhan et al., 2024](#)). Additionally, maintaining attractive physical infrastructure (72.7%) helps attract patients, which supports steady revenue streams. This is consistent with studies by [Onder et al. \(2022\)](#) and [Ru Gan and Kim \(2025\)](#), which emphasize that physical infrastructure and patient-centered environments are key drivers of financial performance in healthcare facilities.

Furthermore, the excellent geographic accessibility reported by all surveyed HCEs ensures high patient volume, directly supporting financial sustainability ([Traoré, 2024](#)).

Cost Control and Pricing Risks

The reliance on direct fee-for-service pricing (81.8%) allows facilities to secure immediate cash flow and maximize short-term revenue. However, this pricing strategy shifts the financial burden onto patients, making care less affordable and reducing service use among low-income households. [Macha et al. \(2014\)](#) observed that high out-of-pocket costs limit healthcare utilization in resource-

poor areas, creating a conflict between a facility's financial viability and its public health role.

Personnel costs make up a large portion of operating expenses. While tight control of these costs prevents salary burdens from eroding net profits (Adaskou & Hssoune, 2021), the low staff stability (27.3%) seen in this study indicates that cost-cutting measures may lead to poor working conditions and high staff turnover. This turnover can ultimately undermine clinical quality.

Furthermore, the lack of management training among owner-operators often leads to uneven financial planning and inconsistent capital reinvestment, with 63.6% of facilities spending very little on equipment maintenance.

Systemic Financial Vulnerability

The near-exclusive reliance on out-of-pocket household payments (85%) highlights the financial vulnerability of both patients and providers. This funding model makes HCE revenues highly sensitive to local economic fluctuations and changes in household purchasing power (Bihin et al., 2022).

The extremely low participation of health insurance and risk-pooling schemes (3%) reflects broader structural gaps in the DRC's health financing system. As Fenny et al. (2016) and Macha et al. (2014) point out, low enrollment in insurance schemes in Sub-Saharan Africa is often driven by a poor understanding of risk-pooling, low-quality public services, limited benefit packages, and mistrust in financial institutions.

Study Strengths and Limitations

Strengths

- i. **Mixed-Methods Design:** Combining quantitative financial data with qualitative interviews provided a comprehensive view of HCE operations.
- ii. **Triangulated Data Collection:** Using interviews, financial document reviews, and direct observations improved the reliability of the findings.
- iii. **Structured Analysis:** Applying a systematic thematic matrix in Excel ensured a clear, transparent analysis of qualitative trends.

Limitations

- a. **Sample Size:** The small sample size (N = 11) limits the generalizability of the findings to all urban HCEs in Kinshasa or the wider DRC.
- b. **Self-Reported Data:** Financial data from document reviews and interviews may be subject to under-reporting of revenues or overestimation of costs due to tax concerns or social desirability bias.
- c. **Cross-Sectional Scope:** The study evaluated a single fiscal year (2022), which prevents an assessment of long-term financial trends or sustainability.

CONCLUSION

This study shows that while most private, for-profit HCEs in the Bandalungwa health district achieve financial viability, their reliance on direct, out-of-pocket household payments leaves them vulnerable. This financing model links provider solvency directly to the immediate purchasing power of patients, creating a fragile business environment and restricting healthcare access for low-income populations.

To improve both financial sustainability and healthcare access, policymakers in the DRC must work to reduce out-of-pocket expenses by developing comprehensive health insurance systems, risk-pooling mechanisms, and public-private partnerships.

Use of Artificial Intelligence (AI) Declaration: The authors declare that no generative artificial intelligence was used to produce, modify, or manipulate the primary research data. This manuscript underwent formal editorial and linguistic refinement under the sole responsibility and oversight of the authors.

Authors' Contributions:

- N.I.S.: Conceptualization, Data Curation, Formal Analysis, Methodology, Writing – Original Draft Preparation.
- M.M.E.: Methodology, Supervision, Writing – Review & Editing.
- A.M.S. & N.S.N.: Writing – Review & Editing.
- All authors: Conceptualization, Investigation, Validation, Visualization, Writing – Review & Editing.

Data Availability Statement: All data generated or analyzed during this study are included in this published article [and its supplementary information files]. Additional supporting data are available from the corresponding author upon reasonable request, subject to institutional policies.

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