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MicroNOTE

CONCEPTUALIZING HEALTH AND MICROFINANCE NEXUS IN PAKISTAN

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Objective:

This study looks at sector-led approach for health financing through microfinance- whether microfinance sector is currently positioned to serve the needs of the sector, drawing out relevant research to outline potential partnerships. Role of various stakeholders like regulator, microfinance providers, health and insurance providers, government entities shall be explored. Considering the issue of last mile access and quality of health services, feasibility of social franchise model for health shall also be looked into.

1. Introduction

Pakistan's standing in health related indicators, today, is far from ideal. As the Millennium Development Goals (MDGs) reached their deadline in 2015, Pakistan failed to meet all of its health-related goals. Maternal mortality rate (MMR) remains at 170 deaths per 100,000 live births, while Infant mortality rate (IMR) is at 86 per 1000 births. Compared to other South Asian countries, Pakistan currently lags behind in immunization coverage and contraceptive use. Additionally, Pakistan faces the double burden of both communicable diseases (like Malaria, TB) and Non-communicable diseases (NCDs) like Hypertension, diabetes, cancer, acute respiratory diseases with NCDs accounting for 50 percent of adult deaths in the country.[1]

1. World Health Organization (WHO). World Health Statistics; 2015

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Pakistan is going through a transition with population growth, increased demand for healthcare, evolving disease patterns, mass rural to urban migration, the technology boom and increasing life expectancy, which necessitates increased spending on health.[2] However, existing heath care system in Pakistan is far from sufficient in meeting the needs of the burgeoning population. Government spending on health remains abysmally low at 2.6 percent of the GDP (one of the lowest in the region), and per capita expenditure on health in 2014 came out to be USD 36.15 (PKR 3663.4). The landscape of public health service delivery presents a demographically unequal distribution of resources between rural and urban areas, with the rural poor facing a clear disadvantage in primary as well as tertiary health care services. While the coverage of services in rural Punjab and Khyber Pakhtunkhwa (KP) has increased over time, the gap between rural and urban use of health facilities remains stubborn in Sindh and Balochistan.[3] Staff absenteeism, a serious problem in public healthcare delivery, has also led to dissatisfaction with government health services, especially among the most vulnerable in Pakistan.[4]

With dismal state of public health infrastructure, private sector providers' share in the service delivery has increased tremendously. Expenditure as a percentage of private expenditure on health is about 67 percent, with 90 percent of the expenses paid through out-of-pocket (OOP) payments, positioning Pakistan among those countries with the highest share of OPP payments relative to total health expenditure.[5] Considering the high cost of private healthcare, health shocks push approximately 4 percent of the population into poverty each year. This risk is even higher in rural areas—the highest being in KP— with direct correlation with the household size and inverse correlation with the income levels.[6]

a. HEALTH FINANCING IN PAKISTAN

In the health financing domain, revenue generated from government taxation remains one of the primary sources of funds for health sector in Pakistan. This puts health sector in competition with other sectors for public budget. Issues surrounding taxation and government's collection capacity in a largely informal economy, put this source of financing in a further crunch. Therefore, in addition to reallocating existing tax resources for health, there is a need to explore other financing options as well.[7]

Another source of finance for Pakistan's health sector in recent decades has been donor aid and grants. According to some estimates, foreign funding for health has contributed between 4-16 percent to total health

2 Nishtar S. The Gateway Paper; Health System in Pakistan – a Way Forward. Islamabad, Pakistan: Pakistan's Health Policy Forum and Heartfile; 2006.

3 Afzal, U & Yusuf Anam. The State of Health in Pakistan: An Overview, The Lahore Journal of Economics 18 : SE (September 2013): pp. 233–247

4 World Bank. Social protection in health: What are the options for Pakistan? (Pakistan Social Protection Policy Note No. 64406). Washington, DC: 2011

5 Pakistan Bureau of Statistics. National Health Accounts 2013-2014.

6 World Bank. Delivering better health services to Pakistan's poor (Report No. 68258). Washington, DC: 2010.

7 Afzal, U & Yusuf Anam. The State of Health in Pakistan: An Overview, The Lahore Journal of Economics 18 : SE (September 2013): pp. 233–247

expenditures in the last decade. In-kind contributions in the form of technical assistance, medicines/vaccinations and diagnostic kits have also been extended. But considering the targeted and program specific nature of such donations/grants, this source of financing remains largely ephemeral.[8]

Health insurance can be an important buffer against out-of-pocket payments on health but health insurance industry in Pakistan still remains at a nascent stage. In 2012, it contributed an insignificant 1 percent to the total health expenditure.[9] Barriers on supply and demand fronts, hinders the uptake of insurance products. The health insurance market, not only remains concentrated in the urban areas, but due the product design and high costs associated with it, insurance companies primarily serve a particular market segment, i.e. purchasing and providing healthcare as an employee benefit for private companies. Most of the insurance companies have private hospitals on their panels, driving up the costs. Although this cost can be significantly reduced through harnessing public health facilities, the quality of services will need considerable up gradation to come up to the standards.[10] For economically disadvantaged segments of society, health insurance is even more elusive, owing to absence of appropriate products, a lacking heath infrastructure in remote areas and over all dearth of awareness.

2. PAKISTAN'S MICROFINANCE SECTOR – AN OPPORTUNITY OUT OF CRISIS?

Pakistan's microfinance sector has seen impressive growth in the past decade, with the industry moving towards greater outreach and sustainability through the maturity of existing institutions and entry of new players along with several key initiatives for market development. The sector today consists of diverse types of microfinance providers (MFPs), including Microfinance Banks (MFBs) regulated by the State Bank of Pakistan, specialized non-bank microfinance institutions (NB-MFIs) that now will come under the regulatory ambit of Securities and Exchange Commission of Pakistan (SECP). The sector has evolved from a single product, microcredit driven industry towards greater product diversification and today offers the low income households a range of credit, savings, and insurance and remittances products. Many NBMFIs are also extending a series of non-financial services to the clients including but not limited to basic health camps/health education, business development training and gender sensitization.

Microfinance provider's outreach in remote areas and excluded communities positions it uniquely to cater to health needs (financial and non-financial) of its clientele as well. This presents not only a new

8 Nishtar S. The Gateway Paper; Health System in Pakistan – a Way Forward. Islamabad, Pakistan: Pakistan's Health Policy Forum and Heartfile; 2006.

9 Malik, M. A. Universal Health Coverage Assessment Pakistan (2015).

10 Ibid. Nishar, S.

business frontier to scale, but an integrated approach to microfinance help the sector attain further financial sustainability, aiding its clientele in graduating from poverty as well. Rigorous case studies have demonstrated the low marginal costs for MFIs to provide health services can have positive impact on the MFI bottom line.[11]

a. IMPACT OF HEALTH – MICROFINANCE SYNERGIES

Health is a working class person's foremost asset and any health related catastrophe can push the low income people further down the economic ladder. Quite often, underprivileged masses default on their loan payments owing to ill health and financial shocks that it brings about. For microfinance to achieve its objective of providing financial security to the poor, it is crucial for the practitioners to address health security as an important aspect of it.

On the demand side, health financing that includes health micro-insurance, flexible savings and emergency health loans can help the microfinance clients to access and manage the costs of health care.[12] Furthermore, loans for house improvement and water, sanitation and hygiene (WASH) or even treated mosquito nets can drastically improve living conditions, reducing the risks of communicable diseases like Malaria, Dengue and Tuberculosis, leading to healthier lives.

Similarly, on supply side, providing appropriate loan products to private health providers for up gradation of their facilities, purchasing equipment and getting trainings/awareness workshops can also improve the standards of services available to their clients. Social franchising for health is an option that if carried out in tandem with the microfinance sector can lead to a series of benefits for the microfinance clients.

While the microfinance sector cannot be in anyway a substitute for the health system, however, tapping into its extensive outreach and regular contact with the low income communities can do a lot to fill in gaps, at least on information and awareness front. Next section of this study maps various health related initiatives and services that microfinance providers extend towards its clientele in Pakistan.

b. MICROFINANCE FOR HEALTH – STATUS TODAY

A desk research of MFPs in Pakistan showed that around 38 percent of 50 MFPs offer some sort of health related services to its clients to address a range of client health needs. As Table 1 below shows, the MFIs in our survey indicated that maternal care, childhood illnesses and Malaria were two of the highest priorities, followed by malnutrition, and hygiene/sanitation.

11 Metcalfe M, Leatherman S, Gash M, Reinsch M et al. "Health and microfinance—Leveraging the strengths of two sectors to alleviate poverty." Journal of Social Business (2012).

12 Freedom from Hunger. State of the Field of Integrated Health and Microfinance in India, 2012

Table: 1 Services by MFPs as per Health Needs

MFPs	HEALTH NEEDS									
	Maternal Health	Childhood Illnesses	Malnutrition	HIV/AIDS	Hygiene/Sanitation	NCDs	Adolescent	Malaria	Respiratory illnesses	Other dental/eye/ reproductive
KBL	◆	◆	◆			◆	◆	◆	◆	
FMFB	◆	◆				◆		◆	◆	
DSP		◆	◆	◆	◆	◆	◆	◆	◆	◆
FFO	◆					◆		◆		
Naymet	◆	◆						◆	◆	◆
Trust	◆	◆			◆			◆		
SAFCO	◆	◆	◆	◆		◆	◆	◆	◆	
GBTI	◆	◆	◆		◆		◆	◆		◆
NRSP	◆	◆						◆		◆
PRSP	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
TRDP					◆		◆			
Agahe	◆	◆	◆	◆	◆	◆		◆		
BRAC	◆	◆	◆		◆			◆		◆

However, among the two peer groups, it is predominantly the Non-bank MFIs (NBFIs), which are extending health services to its clients in a variety of ways. Some organizations, during their field visits, conduct health awareness workshops educating the clients and members on a wide range of health topics from hygiene, child and maternal health to prevention and management of diseases such as malaria, HIV/AIDS and diabetes. Some run health camps or have established health clinics.

Some institutions offer healthcare financing through health loans and health insurance (for details please refer to Table 2). Most of these NBMFIs have a social component to their missions and visions; hence they are more likely to extend these non-financial health related services, a trend yet not seen among the microfinance banks (MFBs). MFBs, on the other hand, remain limited in the health services/products offered, mainly extending health micro insurance to its clients.

Table 2: Health Products/Services offered by MFPs

MFPs	HEALTH EDUCATION			HEALTH INTERVENTIONS								FINANCIAL PRODUCTS	
	Group	Individual	Health Promotion	Direct Delivery	Contracts with health providers	Negotiated Discounts	Direct Referrals	Mobile Health	CHWs	Distribution of Health Products	Health Loans	Health Savings	Health Microinsurance
KBL					◆								◆
FMFB			◆			◆	◆						◆
TMFB													◆
DSP													◆
FFO	◆												
JWS			◆										◆
Kashf													◆
Naymet Trust	◆	◆	◆		◆	◆	◆		◆	◆			◆
OCT													
SAFCO	◆				◆								◆
SVDP													
Wasil Foundation													
GBTI	◆	◆	◆	◆	◆		◆		◆	◆			◆
NRSP	◆	◆	◆	◆				◆	◆	◆			◆
PRSP	◆		◆						◆				
TRDP													◆
Agahe	◆		◆	◆						◆			
BRAC	◆	◆	◆	◆	◆	◆	◆	◆		◆			
RCDS	◆	◆		◆		◆	◆	◆					◆

13 EFU Life. Pakistan:
Delivering health based plan for women and their families through a non-government organization.

c. HEALTH MICROINSURANCE

Health Microinsurance though a challenging domain owing to the issue of last mile access to health facilities compounded by the lack of awareness, has a great potential to solve the health financing puzzle if paid attention to.

Many MFPs are experimenting with various operation models and distribution channels, to come up with a product which is suitable to the needs of the target segment, feasible for the insurance provider. One such innovative insurance product is the Hospital Cash Plan offered to its clients by Damen Support Program (DSP) as a mandatory bundled product, in collaboration with EFU Life. This product is a hospitalization reimbursement plan where in case the insured borrower, as result of Accident or Sickness is confined as an inpatient within a hospital for at least twenty-four (24) consecutive hours, under the continuous attendance of a Physician, then EFU Life pays a daily cash benefit. In case of confinement to Intensive Care Unit (ICU), the benefit payout is doubled. Now the Caesarian Section Surgery for child birth, has recently been added in the benefits.[13]

From April 2015 to November 2016, 110,000 lives have been covered by Hospital Cash Plan. This high number can be attributed to the significant effort made for awareness building giving special emphasis on explaining to the customers how to make claim for this benefit.

Table 3: EFU Health Micro-insurance factsheet

Product details	Hospital Cash Plan benefit package/year
Type of cover	Hospitalization
Term	1 year renewable
Enrolment ages	Eligible enrolment age: Between 18 & 64 years nearest birthday Eligible coverage age: Between 18 & 65 years nearest birthday
	USD 3.25 per covered member
Benefit amount	▪ Daily cash benefit = USD 10 ▪ Additional ICU benefit = USD 10 ▪ Caesarian Section Surgery = USD 100
Maximum hospitalization benefit limit	The benefit can be availed for a maximum of 180 days in a year. Consecutive hospitalization for more than 24 hours, the payment benefits (ICU benefit and/or main benefit) may contribute for a maximum of 30 consecutive days.
Some Key exclusions	▪ Any pre-existing condition ▪ Self-inflicted injury, attempted suicide, abuse of alcohol, drug addiction or abuse ▪ Hospitalization for diagnostic purposes only, dental treatment ▪ Injuries as a result of illegal act of the covered
Elimination/ Waiting period	**Starting from enrolment:** ▪ For sickness benefit: 10 days ▪ For accidental benefit: No waiting period **Between successive hospitalization:** 30 days

3. PROPOSED MODELS: SOCIAL FRANCHISING FOR HEALTH AND TELEMEDICINE

Owing to the challenges of last mile access, any initiative pertaining to health has low chances of success in the absence of adequate health infrastructure. This section draws upon some innovative health care models to gauge how the issue of last mile access can be tackled and the role that microfinance sector can play in this regard. Two of the models analyzed here are Social Franchising for Health and Telemedicine. Global application of these models is also looked into to establish their feasibility.

a. SOCIAL FRANCHISING FOR HEALTH

Considering the important role that private sector is playing in provision of health services to a large segment of population in developing countries, globally, Social Franchising has become a popular model/ strategy for strengthening the health systems as well as to ensure a standardized provision of quality services to the clients.

Utilizing the principles of commercial franchising, a social franchise for health can be defined as "a network of private sector healthcare providers that are linked through agreements to provide socially beneficial health services under a common franchise brand. A 'franchisor' (typically a non-profit) manages the brand and oversees the administration of the program."

Social franchise programs often-times share these characteristics:

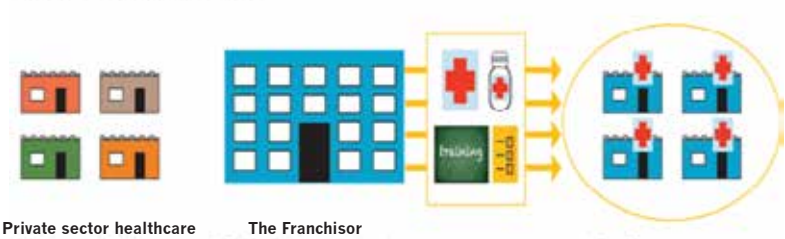
- The private healthcare providers (or franchisees) are not employed by the social franchise program
- There are fees for services or medical commodities that are provided
- The franchised clinical services are linked to standards and protocols[14]

• ORGANIZATION OF SOCIAL FRANCHISE MODEL

Social franchise begins with a parent agency (also called a franchisor) creating and marketing a brand name for certain health commodities and clinical services. Private health care providers can become the purveyors of the franchise with access to the brand name and subsidized commodities. These healthcare providers agree to receive periodic trainings and performance monitoring, and are now recognized as franchisees. They continue to retain complete ownership over their outlets, and continue to charge fees for their services (Figure 1), while paying a decided upon amount as the franchise fee to the parent franchisor company.[15]

14 Social Franchises for Health. About Social Franchises. Retrieved from: http://sf4health.org/about-social-franchises
15 Ibid.

The Clinical Social Franchise Model



Private sector healthcare providers may offer a range of health services, with little or no quality oversight from an independent body.

The Franchisor (an independent agency or program) recruits private sector health providers, and offers them:

- a shared brand identity, and marketing support
- access to subsidized branded health commodities
- trainings in better clinical and business management practices
- stipulated standards in relation to the franchised commodities and services, and quality oversight

As Franchisees, private sector healthcare providers now offer franchised health services and commodities that are linked to protocols and standards.

Figure 1:

Source: Social franchises: The bridge between private healthcare providers and national health insurance programs (2015).

In health ecosystems with increasing dependence on private sector health providers, social franchising offers a series of benefits to the providers, the clientele, the government and overall health systems (Figure 2). For the clients, it translates into access to high quality and reliable health services at affordable prices. The franchisees, driven by the incentive of ownership, take great care to make the setup a success, benefiting in return from the increased clientele base that comes with being associated with a brand name and quality training/ equipment. By placing the onus of expansion to outside entrepreneurial individuals, it takes off the burden from public health systems, minimizing the risks of negligence owing to quality assurance and monitoring protocols in place leading to a better regulated private sector. Since the parent franchisor company has an interest in strictly enforcing compliance to franchise standards to protect their brand name, they seek to ensure that all franchisees are consistent in the type and quality of care they provide to inspire the trust of consumers.[16]

Many of these franchises run on a hub and spoke model, where microclinics and pharmacies are associated with a regional office and/or hospital. For micropharmacies, the regional office ensures a supply of quality medicines while for microclinics, the regional hospitals are used not only as part of a referral system where more complicated cases are forwarded but they also vet the staff off the clinics, consistently according to set standards.[17]

16 Kiva Microfunds. (2012). Kiva Innovations: Improving global health with micro-clinic and micro-pharmacy franchises.

17 Ibid.

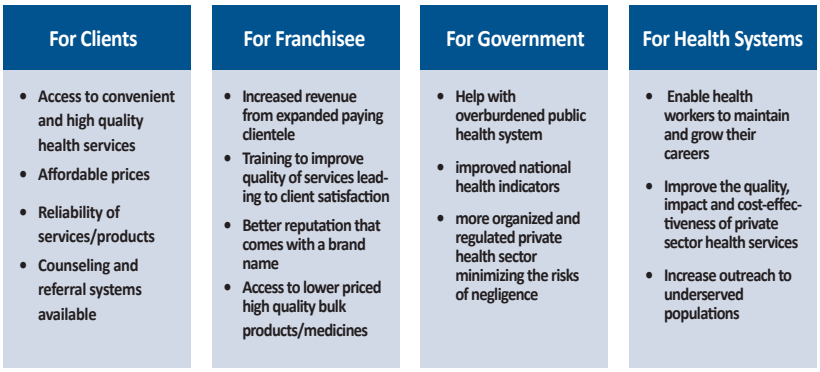


Figure 2: Benefits of Social Franchising for Health

• SOCIAL FRANCHISING CASE STUDIES

Globally, Social franchise model has been used in ingenious ways to bring affordable health care to masses. In 2013, social franchises for health operated in over 40 countries, providing a range of services including maternal and child health, reproductive health, malaria, and tuberculosis.[18]

i. BLUESTAR PILIPINAS[19]

BlueStar is a franchise brand developed and owned by Marie Stopes International (MSI), a UK-based non-profit agency. At the national level, the franchise is managed by the Population Services Pilipinas, Inc. (PSPI). All franchisees are midwives that work exclusively in the private sector, and all are authorized, under the BlueStar brand, to provide the following franchised services, alongside any other non-franchised services already offered at the clinics:

- Family planning: family planning counseling, contraceptives, and referrals for tubal ligations

- Women's reproductive health services: Pap smear and management of reproductive tract infections

PSPI is responsible for the oversight and expansion of the program. The agency also provides franchisees with competency trainings, technical assistance, subsidized commodities and supplies, quality monitoring and assurance services, promotions and marketing, and branding support. When a midwife agrees to become a franchisee, she undergoes trainings on BSP's business systems module and a comprehensive competency-based clinical training on FP (that includes IUD didactics and practicum). After successful completion of training requirements, the franchisees' facilities are renovated with PhilHealth accreditation standards in mind. They are also given the equipment they need to provide MNCH and reproductive and sexual health (RSH) services, as well as a six-month supply of essential commodities.

18 Social franchises: The bridge between private healthcare providers and national health insurance programs (2015) by The Global Health Group Global Health Sciences University of California, San Francisco

19 Ibid.

When a franchisee first joins BSP, the initial package of clinic equipment and supplies—amounting to approximately 50,000 PHP—is subsidized by PSPI. Franchisees pay back part of the cost of the equipment and supplies through a monthly payment of 1,000 PHP (22 USD) for three years. An additional yearly membership fee of 1,500 PHP (33 USD) is also paid by the franchisees to cover costs associated with the technical assistance provided by PSPI. PSPI uses the revenue generated from these fees, as well grant money from MSI, to finance the operational costs of BSP. Midwives earn revenue from the direct sale of health services and FP commodities to clients (UCSF, 2015).

Recently, the Blue Star franchise joined hands with Government of Philippines to accredit the midwives in order to link them to the National Health Insurance Program (NHIP). Those that are accredited under the NHIP receive reimbursements from that program from the provision of services to enrolled beneficiaries. This partnership has not only reduced the burden of cost on the poor clients but has become a source of revenue for the franchisees, ensuring sustainability of their enterprises.

ii. CHILD AND FAMILY WELLNESS (CFW CENTERS) KENYA

Another such social franchise, working to solve the problem of last mile access and distribution in health is Child and Family Wellness Shops in Kenya. Operated by the parent franchisor, HealthStore Foundation CfW centers/shops are a chain of micro-clinics and micro-pharmacies in rural Kenya. Owned and run by professional nurses, these micro-clinics provide primary health care to the communities, providing treatments for conditions that cause 70 to 90% of child morbidity and mortality in developing countries, including malaria, diarrhea and worms. On average, these shops provide $1,000 per month in income for the franchisees. Franchisees receive extensive training on CFW shops standards and procedures by the franchisor.

Similarly, micro-pharmacy franchises are small-scale pharmacies that are typically located in remote rural areas. Their objective is to ensure supply of basic essential medicines to these areas, mitigating the risks of counterfeit drugs in the market. The franchisors ensure that the medicines they supply are of high quality and they provide franchisees with training in essential medications and treatments relevant to their local communities.[20]

Kiva Microfunds a non-profit organization, which extends loans to small scale entrepreneurs has joined hands with the Health Store Foundation, where it provides startup capital to the nurses and pharmacists wanting to setup a clinic or a pharmacy. It also extends a series of renovation and up gradation loans to the nurses who want to improve the range of services they provide.

20 Kiva Microfunds. (2012). Kiva Innovations: Improving global health with micro-clinic and micro-pharmacy franchises.

b. TELEMEDICINE

Another delivery model being employed across the world to bring health care to remote areas is Telemedicine. WHO, defines telemedicine as, "The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities".

Harnessing the advancements in information and communications technology, Telemedicine uses videoconferencing and various software and hardware applications to connect patients with geographically distant doctors.

• TELEMEDICINE CASE STUDIES

Research shows that Telemedicine programs decrease the number of referrals to off-site facilities and reduce the need for patient transfers. Remote care and diagnosis via telemedicine in less-economically developed countries thus benefits both patients and the health care system by reducing the distance travelled for specialist care and the related expenses, time, and stress (WHO, 2010) and it is being employed both in the Global North as well as Global South to bring tertiary health care to otherwise excluded patients.

i. APOLLO/EQUITAS PARTNERSHIP

Equitas, a microfinance organization based in Chennai, has employed the Telemedicine model to bring health care services to its clients. Equitas has setup three telemedicine centers in its regional branches in collaboration with the Apollo Hospitals. Located in urban slums, the centers are staffed with a trained nurse, basic diagnostic equipment, laptops with videoconferencing applications and an internet connection. Female clients of Equitas can schedule an appointment at the center and consult with the doctor through videoconferencing. Center based nurses measure vital signs such as blood pressure and heartbeat rate through equipment that transmits readings directly to the doctor and into a patient's computerized medical file. The per-visit cost to the patient is 50 INR (.96 USD). Following the successful pilot, Equitas plans to scale the telemedicine centers to more of its 300 branches that provide financial services to over 1 million clients.[21]

ii. SEHAT KAHANI

Another organization, using a similar model to address the distribution challenge of health sector in Pakistan is Sehat Kahani. A social impact initiative, Sehat Kahani envisions to tap into the pool of female doctors

21 Freedom from Hunger. State of the Field of Integrated Health and Microfinance in India, 2012

who are unable to work due to family commitments and other social dynamics, brining basic health care to underserved communities in urban slums of Pakistan. Much like Equitas/Apollo Model, E-Health centers run by Sehat Kahani are staffed by a trained nurse and equipped with basic equipment and a laptop with internet connection. The nurse is usually selected from within the community and is paid a monthly salary. The patient can schedule an appointment at the center and is charged a minimal fee, a portion of which goes to the doctor while the rest is used to cover the administrative costs of the center. Currently Sehat Kahani has established 8 E-Health centers in various areas of Karachi and Abbottabad.[22]

4. FOSTERING SYNERGIES: TELEMEDICINE, MICRO-CLINICS AND MICROFINANCE

As the microfinance sector moves towards achieving growth and sustainability through greater market segmentation and product diversification, health financing can become an important sector for the microfinance providers. Past few years have seen a substantial increase in individual loans, which depicts an appetite for customized, need based microfinance product. It is time now to move beyond the understanding of financial services solely for income generating activities and integrate relevant products to cater to the non-financial needs of our clients.

Health landscape in Pakistan, today, faces many challenges in efficiently serving the burgeoning population of Pakistan; a disconnect between public and private sectors, policy gaps, human resource capacity issues and funding limitations. Various models of public-private partnerships can play a great role to alleviate these challenges and microfinance sector can play the supporting role to overcome the financial needs on both the supply and demand side.

Based on the innovative initiatives reviewed in the previous section, we suggest a model bringing together the elements of social franchising, telemedicine aided by loan and microinsurance offering from the microfinance sector (Figure 3).

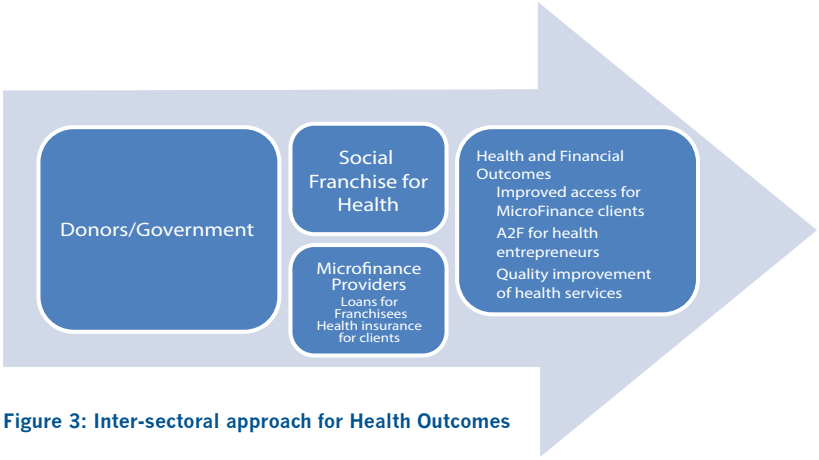


Figure 3: Inter-sectoral approach for Health Outcomes

22 Sehat Kahani. About US. Retrieved from: http://sehatkahani.com/#!/services

Capitalizing on the network of entrepreneurial professional nurses and Lady Health Workers (LHWs), government in collaboration with an NGO can strategize to create social franchise for health, along the lines of CFW microclinics in Kenya. The mandate of such a franchise would be provision of basic health services like treatment of common ailments, pre and post natal care, child and mother wellness, health education for prevention of communicable as well as non-communicable diseases. While the parent NGO franchisor can take the responsibility of supply chain, training, monitoring and evaluation, government can provide supportive role in recruitment as well as monitoring and evaluation. Basic Health Units (BHUs) in rural areas make for a great entry point, as currently these BHUs are suffering from a plethora of issues including staff absenteeism and lack of products and equipment. By adopting these BHUs and giving them under the ownership of enterprising individuals would not only help capitalize on existing infrastructure, limited though it may be, but it will also help saving a substantial startup cost.

Similarly, with 110,000 trained Lady Health Workers, Pakistan has one of the largest LHW network in the world, whose houses serve as 'Health houses' in their respective communities, serving 60 percent of Pakistan's population. An evaluation of the LHW program yielded that communities with an active LHW in their midst had better health outcomes than control communities. This network can be tapped into for the franchise model with each Lady Health Worker going on to the next mile and setting up micro-clinics within their homes. Considering the legal restrictions that bar nurses or LHWs from making a diagnosis and prescribing medicine, the component of telemedicine can be introduced where each micro-clinic equipped with a laptop and an internet connection and linked with a regional hospital so the physicians can examine the patients remotely, bringing advanced health services to the doorstep. Organizations like Sehat Kahani make for good partners in such a model as their expertise can be drawn upon and lessons learnt rather than re-inventing the wheel.. This model also resolves the issue of sustainability of LHW program, owing to lack of career progression path for the LHWs and the decentralized nature of the program.

Microfinance sector can be a natural ally in such an initiative in not only pin pointing the areas where such a setup would be successful based on their expansion patterns but also by becoming a source of start-up capital for the entrepreneurial nurses and LHWs. In addition to catering to the supply side financial needs of this model, where each micro-clinic can be treated as a small enterprise, by coming up with a range of health loans and insurance products, it can play its part in meeting the demand side need of the financial services. One of the daunting challenges with insurance products is their reimbursement policies which tend to cater to products and services availed only at the hospitals on their panels, an issue which renders such products useless or even costlier for clients residing in far flung areas. Such a linkage between the insurance products and franchised micro-clinics, will serve the clients by reducing their out of pocket expenditure while becoming a source of revenue for the franchisee. In Phillipines, one such social franchise for health, Blue

Star Philipinas has recently been linked with the National Health Insurance Program reaping mutual benefits for the franchisee as well as the clients.[23]

While this note gives a conceptual framework for the tele-microclinics, any such initiative needs a concentrated effort from the stakeholders involved; government, interested NGOs, microfinance providers as well as insurance companies. Bringing such a diverse array of stakeholders together is a mammoth challenge on its own. Robust regulatory frameworks to ensure safe and responsible practices, especially with the arrival of telemedicine, are needed before any such program is launched on a mass scale. However, examples from across the globe as well as right from across the border are a proof of real possibility of such undertakings.

23 Social franchises: The bridge between private healthcare providers and national health insurance programs (2015) by The Global Health Group Global Health Sciences University of California, San Francisco

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