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CGAP WORKING GROUP ON
MICROINSURANCE

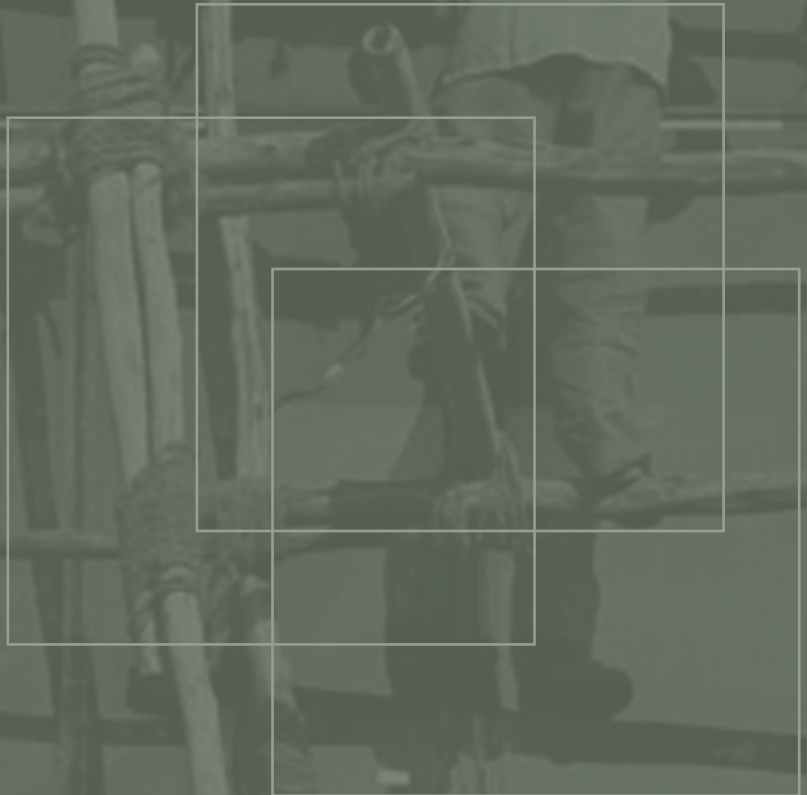


International
Labour
Office
Geneva

Protecting the poor

A microinsurance compendium

Edited by
Craig Churchill



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¹ CGAP is a consortium of 33 public and private development agencies working together to expand access to financial services for the poor in developing countries. CGAP was founded by these aid agencies and industry leaders to help create permanent financial services for the poor on a large scale (often referred to as “microfinance”). CGAP’s unique membership structure and network of worldwide partners make it a potent convening platform to generate global consensus on standards and norms. As such, CGAP is a resource centre for the entire microfinance industry, where it incubates and supports new ideas, innovative products, cutting-edge technology, novel mechanisms for delivering financial services, and concrete solutions to the challenges of expanding microfinance (see www.cgap.org).

As one of the Working Group's research activities, this book is the culmination of a four-year process to understand good and bad practices in providing insurance to the poor. It began with a research project co-financed by DFID, GTZ (commissioned by BMZ), ILO and SIDA, and managed by the ILO. Thanks to their contributions, this project supported the production of 25 case studies of microinsurance operations around the world, which serve as the foundation on which this book is built. On behalf of the Working Group, I would like to thank the management and staff of the institutions analysed for these case studies who allowed us to dissect their products and operations and publicly air their trials and tribulations along the way to providing quality microinsurance products.

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Table of Acronyms

AAC/MIS	Americas Association Cooperative/Mutual Insurance Societies
AD&D	Accidental death and disability
ADB	Asian Development Bank
AFL-CIO	American Federation of Labor – Congress of Industrial Organizations
AIDS	Acquired immunodeficiency syndrome
AIG	American International Group
AIMS	Automated insurance management system
AKAM	Aga Khan Agency for Microfinance
ALM	asset-liability matching
ALMAO	All Lanka Mutual Assurance Organization (Sri Lanka)
ARDCI	Agriculture and Rural Development Center of Catanduanes, Inc. (Philippines)
ASA	Activists for Social Alternatives (India)
ASCA	Accumulating savings and credit association
AssEF	Association d’Entraide des Femmes (Benin)
ATM	Automatic teller machines
BM	Bienestar Magisterial (El Salvador)
BMZ	Federal Ministry for Economic Cooperation and Development (Germany)
BOP	Bottom of the pyramid
BRAC	Bangladesh Rural Advancement Committee
CARD	Center for Agricultural Research and Development (Philippines)
CARE	Cooperative for Assistance and Relief Everywhere, Inc.
CBO	Community-based organization
CCA	Canadian Co-operative Association
CEO	Chief executive officer
CETZAM	Christian Enterprise Trust Zambia
CGAP	Consultative Group to Assist the Poorest
CHR	Community Health Fund (Tanzania)
CICS	Claims in course of settlement
CIDR	Centre International de Développement et de Recherche (France)
CIF	Centre d’Innovations Financières
CMF	Centre for Microfinance (Nepal)
CoP	Colombian Peso (currency)
CPI	Consumer Price Index
CRIG	Community rural insurance group
CRMST	Coordination Régional de Mutuelles de Santé de Thiès (Senegal)
CSG	Commissioners Standard Group
CSR	Corporate social responsibility
CU	Credit union
CUNA	Credit Union National Association (United States)
DAC	Development assistance committee
DFID	Department for International Development (United Kingdom)
DID	Développement International Desjardins (Canada)
FAQ	Frequently asked questions

FCFA	Franc de la Communauté financière de l'Afrique
FDCF	Financial Deepening Challenge Fund
FFP	Fondo Financiero Privado (Bolivia)
FHPL	Family Health Plan Limited (India)
FINCA	Foundation for International Community Assistance
FSB	Financial Services Board (South Africa)
GK	Grameen Kalyan (Bangladesh)
GLICO	Gemini Life Insurance of Ghana
GNF	Guinean Francs (currency)
GPS	Grameen Pension Scheme (Bangladesh)
GRET	Groupe d'échange et de recherche technologique (France)
GTZ	Gesellschaft für Technische Zusammenarbeit (Germany)
GUPR	Gross unearned premium reserve
HIV	Human immunodeficiency virus
IAIS	International Association of Insurance Supervisors
IBNR	Incurred but not reported claims
IBSL	Insurance Board of Sri Lanka
IC	Insurance Commissioner
ICD	International Claims Diagnostic
ICMIF	International Cooperative and Mutual Insurance Federation
ID	Identification
IDB	Inter-American Development Bank
ILO	International Labour Organization
IRDA	Insurance Regulatory and Development Authority (India)
IT	Information technology
ITN	Insecticide-treated nets
JCCU	Japanese Consumers' Co-operative Union
K	Kwacha (Malawian currency)
KSK	Kasagana Ka (Philippines)
LIC	Life Insurance Corporation of India
LKR	Sri Lankan Rupee (currency)
MAF	Mutual assistance fund
MBA	Mutual benefit association
MDGs	Millennium Development Goals
MFI	Microfinance institution
MHIB	Micro Health Insurance for Poor Rural Women in Bangladesh
MHO	Mutual health organization
MIAN	Micro Insurance Association Netherlands
MIS	Management information system
MIX	Microfinance Information eXchange
MMF	Members' mutual fund
MORO	Meeting of Reinsurance Officials
MOUS	Memorandums of understanding
MUSCCO	Malawi Union of Savings and Credit Cooperatives
NACSCU	National Association of Credit Unions (Poland)
NGO	Non-governmental organization
NHHP	Nsambya Hospital Healthcare Plan (Uganda)
NIC	National Insurance Company (India)
NUCS	National Union of Cooperative Societies (Jamaica)
OECD	Organisation de coopération et de développement économique/Organisation for Economic Co-operation and Development
OI	Opportunity International
OIBM	Opportunity International Bank of Malawi
PAD	Provision for adverse deviation
PC	Personal computer
PCC	Protected cell company
PDA	Personal digital assistants
Php	Peso (Philippines currency)
PHR	Partnership for Health Reform (USA)

PML	Probable maximum loss
POGI	PhilHealth Organized Group Interface
PPP	Public-private partnership
PRSP	Poverty-reduction strategy paper
Q.	Quetzal (Guatemalan currency)
R	South African Rand (currency)
RBC	Risk-based capital
RIMANSI	Risk Management Solutions, Inc. (Philippines)
ROSCA	Rotating savings and credit association
RS	Reinsurance Services
Rs.	Rupees (Indian currency)
SA	South Africa
SACCO	Savings and credit cooperatives
SAIA	South African Insurance Association
SBS	Seguro Basico de Salud (Bolivia)
SEEP	Small Enterprise Education and Promotion
SEWA	Self-employed Women's Association (India)
SHG	Self-help group
SI	Seguro Integral (Paraguay)
SIDA	Swedish International Development Cooperation Agency
SK	Shashtho Kormis (health paramedics in Bangladesh)
SKOK	Cooperative Savings and Credit Unions (Poland)
SMI	Seguro Materno-Infantil (Peru)
SOCODEVI	Société de Coopération pour le Développement International (Canada)
SS	Shashtho Shebikas (community health workers in Bangladesh)
SSS	Society for Social Services (Bangladesh)
STEP	Strategies and Tools against Social Exclusion and Poverty
TA	Technical assistance
TOT	Training of trainers
TPA	Third-party administrator
TPD	Total and permanent disability
TSKI	Taytay Sa Kauswagan (Philippines)
TUW SKOK	Mutual Insurance Company of Cooperative Savings and Credit Unions (Poland)
TV	Television
TYM	Tao Yeu May (Viet Nam)
UEMOA	Union économique et monétaire d'Afrique de l'Ouest
UHC	Uganda Health Cooperative
UIC	United India Insurance Company, Ltd.
UK	United Kingdom
UMASIDA	Umoja wa Matibabu Sekta Isiyo Rasmi Dar es Salaam
UMSGF	L'Union des Mutuelles de Santé de Guinée Forestière (Guinea)
UNCTAD	United Nations Conference on Trade and Development
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
US\$	United States Dollar (currency)
USA	United States of America
UTM	L'Union Technique de la Mutualité Malienne (Mali)
VHS	Voluntary Health Service (India)
WHO	World Health Organisation
WWF	Women's World Foundation (Colombia)
Zl	Zloty (Polish currency)
ZOC	Zone operations centres

Introduction

Low-income households are vulnerable to risks and economic shocks. One way for the poor to protect themselves is through insurance. By helping low-income households manage risk, microinsurance can assist them to maintain a sense of financial confidence even in the face of significant vulnerability. If governments, donors, development agencies and others are serious about combating poverty, insurance has to be one of the weapons in their arsenal.

Among low-income populations, risk pooling and informal insurance are not entirely new. Informal risk-sharing schemes have been around for generations, even in some of the most inaccessible places. However, these schemes are usually limited in their outreach and the benefits typically cover only a small portion of the loss. A key aspect of the interest in microinsurance is to explore ways of significantly increasing the number of poor households that have access to insurance while enhancing the benefits.

I In search of good and bad practices

To learn how to extend insurance to low-income households, the CGAP Working Group on Microinsurance launched a research project in 2003 to document the experiences of microinsurance operations around the world and identify good and bad practices.¹ This project conducted a series of case studies of insurance companies, microfinance institutions (MFIs) and community-based insurance schemes from around the world to learn about the provision of life and health insurance to the poor. While other types of insurance are also relevant for the low-income market, including property and agriculture insurance, this initiative focused on the two risks – death and illness – that are most frequently identified in demand research.

¹ SIDA, DFID, GTZ and the ILO provided support for this project.

The research focused on organizations that had at least three years of experience and covered at least 3,000 lives in order to assess their results rather than their plans. The project primarily looked at experiences in Africa, Asia and Latin America, and sought microinsurers that employed a variety of different models and delivery structures, such as:

- Partnerships between insurers and distribution agents such as cooperatives and MFIs²
- Regulated insurance companies that serve the low-income market directly
- Healthcare providers offering a financing package and absorbing the insurance risk
- Community-based programmes that pool funds, carry risk and manage a relationship with a healthcare provider
- Government-sponsored or -subsidized insurance schemes
- Self-insuring MFIs that assume the risk of offering insurance to their clients

The potential sample of microinsurance schemes that met these criteria is not extensive. Many microinsurance schemes are new or the products were only recently introduced. Most microinsurers have focused on the simplest insurance products to manage, especially credit life. After that, the volume of available microinsurance reduces as product management complexity increases. To some extent, the products most in demand in this under-served market, such as health insurance, are precisely those that are the least available.

Nevertheless, a number of appropriate organizations were identified and contacted, and they agreed to go under the microscope of (largely) external analysts. Most case studies were conducted by two-person teams that consisted of an insurance expert and a development professional who together could consider both the technical and the social aspects of extending insurance to the poor. The teams all used the same research frameworks and analysed their findings using a common case study outline to facilitate an analysis of lessons across the microinsurance schemes.³

² Throughout this book, the term microfinance institution is used to refer to any formal or semi-formal organization that has savings and/or credit transactions with low-income households, which includes microcredit NGOs, credit unions or savings and credit cooperatives (SACCOs), regulated microfinance banks and others. According to the Microcredit Summit (www.microcreditsummit.org), at the end of 2004, there were more than 3,000 MFIs around the world providing credit and other services to 92 million low-income people, of whom 66 million were among the poorest when they took their first loan.

³ There are a few exceptional case studies, structured differently in order to consider different perspectives on microinsurance. For example, ICMIF (2005), *Lessons learnt the hard way*, analyses nine insurance companies, current or former members of the International Cooperative and Mutual Insurance Federation, which all experienced difficulties in one way or another; their experiences are documented anonymously. Similarly, Leftley (2005) looks at microinsurance experiences from the perspective of a technical assistance provider, Opportunity International, which has supported numerous MFIs to negotiate partnerships with insurance companies.

In all, twenty-five case studies were conducted, analysing the experiences of more than 40 organizations that are involved in microinsurance either as a risk carrier, distribution channel or both, as summarized in Table 1. Examples from the case studies are sprinkled liberally throughout this book to illustrate lessons and recommendations. Instead of repeating the bibliographic references from these case studies, readers are instructed to take note that whenever there is an uncited reference to these microinsurance providers, the experience is drawn from the associated case study. Appendix I specifies which schemes are covered in which case studies.⁴

This book synthesizes lessons drawn from these experiences. These lessons were analysed by 38 authors with a range of backgrounds (see Appendix II for the authors' biographies) – including academics and actuaries, insurance and development professionals – most of whom participate in the CGAP Working Group on Microinsurance. The conclusions they reach and recommendations they make reflect their personal opinions and are not general recommendations from the Working Group as a whole.

Some of the findings remain inconclusive. Observant readers are likely to notice differences of opinion on a range of issues, including the usefulness of credit life insurance, the role of reinsurance, the appropriateness of endowment policies, the benefits of composite products, the enthusiasm of commercial insurers for the low-income market, the promotion of informal or unregulated insurance schemes, exclusions for pre-existing conditions, and many more.

By and large, however, despite the fact that this book covers different insurance products delivered by a variety of institutional arrangements across four continents, a clear picture of microinsurance is beginning to emerge, particularly regarding the challenges of insuring the poor as well as many of the solutions. The findings reveal that microinsurance is indeed viable, and even profitable under certain circumstances, but a number of difficulties must be overcome for it to succeed.

2 Target audience

The primary audience for this book are insurance professionals and practitioners working in the field who are currently offering insurance to low-income persons or thinking about doing so. This book was written in hopes that they would be able to learn from the experiences of those who came before, both those who have succeeded and those who have failed.

⁴ The case studies are available on:
www.microfinancegateway.org/section/resourcecenters/microinsurance

This book is also intended for persons who assist practitioners, such as technical assistance providers and donors. By having a better understanding of the challenges and potential solutions associated with the provision of insurance to the poor, it is hoped that these individuals and organizations can use their financial and human resources more effectively to expand access to insurance.

Policymakers and regulators represent a third category of readers. As a new field of activity, microinsurance often operates in an environment that was not designed for it, and which can even be characterized as hostile. By acquiring an appreciation for the key differences between insurance and microinsurance, and recognizing where microinsurance potentially fits into a broader social protection framework, regulators and policymakers can begin to craft an enabling environment to nurture and support the growth and development of microinsurance and to promote more inclusive insurance markets.

3 Structure of the book

This book is organized into six parts. The first part, Principles and Practices, defines microinsurance, provides insights into the risk-management needs of low-income households and explains the critical social protection function of microinsurance.

Part 2 summarizes lessons about specific types of products, namely health insurance, long-term life insurance and short-term insurance linked to savings and credit products. This part also explores the adaptation of insurance products to address the characteristics of women and children.

The third part of the book explores microinsurance operations in detail. It includes chapters on product design, marketing, premium collection, claims, pricing, financial and risk management, governance, organizational development and loss control. It concludes with a chapter on benchmarking that examines performance ratios of the microinsurance schemes.

Microinsurance can be delivered through a variety of institutional arrangements. Part 4 examines these arrangements to analyse the conditions in which one might be preferable to the others. These chapters consider the partner-agent model, the community-based approach, insurance companies owned by networks of savings and credit cooperatives, retailers as distribution channels, and microfinance institutions. One chapter analyses the advantages, disadvantages and conflicts of interests of various organizational arrangements for delivering health insurance.

Part 5 assesses the roles of key stakeholders, including donors, regulators, governments, insurers and reinsurers, and technical assistance providers. The book concludes with Part 6, which summarizes the strategies needed to achieve the right balance between coverage, costs and price, and provides an outlook on future developments in microinsurance.

Table 1

Microinsurance providers and products

<i>Institution – Start of microinsurance</i>	<i>Country</i>	<i>Persons covered* (year of data)</i>
Activists for Social Alternatives (ASA) – 1993	India	55,000 (2004)
All Lanka Mutual Assurance Organization (ALMAO) – 1991	Sri Lanka	50,000 (2004)
American International Group Uganda (AIG Uganda) – 1997	Uganda, Tanzania U.R., Malawi	1.6 million (2003)
Association d'Entraide des Femmes (AssEF) – 2003	Benin	2,300 (2004)
Bienestar Magisterial (BM) – 1969	El Salvador	75,000 (2003)
BRAC Micro Health Insurance for Poor Rural Women in Bangladesh (MHIB) – 2001	Bangladesh	12,000 families (2004)
CARD Mutual Benefit Association (CARD MBA) – 1994	Philippines	580,000 (2003)
Christian Enterprise Trust Zambia (CETZAM) – 2000	Zambia	5,000 (2004)
Columna – 1993	Guatemala	54,000 (2004)
La Coordination Régional de Mutuelles de Santé de Thiès (CRMST) – 1989 (first MHO)	Senegal	75,000 (2005)
Delta Life – 1988	Bangladesh	859,000 (2002)
La Equidad Seguros – 1970	Colombia	30,000 (2004)
FINCA Uganda – 1997	Uganda	37,000 (2003)
Grameen Kalyan – 1996	Bangladesh	58,000 families (2004)
International Cooperative and Mutual Insurance Federation (ICMIF)	Global	Not applicable
Karuna Trust – 2002	India	61,000 (2004)
Madison Insurance – 2000	Zambia	30,000 (2003)
MAFUCECTO – 2004	Togo	556 (2004)

* It would not be appropriate to add up these numbers to estimate the total number of persons covered by microinsurance since this is just a sample of the schemes in operation, and because it would

<i>Main microinsurance product</i>	<i>Institutional type/ Delivery model</i>
Term life (linked to credit)	MFI that switched several times between partner-agent and self-insurance
Endowment and funeral	Private-sector insurance company created by a network of credit and savings associations; an informal scheme that was licensed in 2002
Accidental death and disability (AD&D) integrated with credit life	Private-sector insurance company providing a micro-insurance product through partnerships with 26 MFIs
Health	MFI offering microinsurance in-house
Health	Employment-related scheme for a teacher's union
Health	An unregulated insurance scheme linked to an NGO healthcare provider with a network of clinics and an associated microfinance NGO
Life, integrated credit life and disability	Mutual insurance company associated with an MFI
Credit life, funeral, property	An OI-affiliated MFI that has worked with two private insurance companies to provide products
Life/disability insurance	Insurance company owned by the credit unions
Health	An apex body of mutual health organizations (MHOs)
Endowment	Private-for-profit insurance company serving the low-income market directly
Life and disability	Mutual insurer owned by credit unions (but also uses partner-agent model with an MFI)
AD&D with credit life	MFI partnering with AIG Uganda
Health	Insurance provided by healthcare provider
Not applicable	A global network of cooperative and mutual insurance companies; the experiences of nine anonymous ICMIF members are described in one case study, ICMIF (2005), <i>Lessons learnt the hard way</i>
Per diem income during hospitalization	NGO in partnership with state insurance company (NIC), follows partner-agent model
Credit life and funeral	Private insurance company partnering with 4 MFIs
Credit life	An insurance department of a credit union association

result in some double counting. For example, the numbers for TSKI and CETZAM are also included in the OI figures; similarly, the FINCA Uganda numbers are included in AIG Uganda.

<i>Institution – Start of microinsurance</i>	<i>Country</i>	<i>Persons covered (year of data)</i>
Malawi Union of Savings and Credit Cooperatives (MUSCCO) – 1980	Malawi	56,000 (2003)
Opportunity International (OI) – 2002	Global	2.7 million (2005)
Pulse Holdings Ltd. – 2001	Zambia	2,200 (2003)
Seguro Basico de Salud (SBS) – 1999-2003	Bolivia	Not available
Seguro Integral (SI) – 2002	Paraguay	15,600 (2002)
Seguro Materno-Infantil (SMI) – 1998-2001	Peru	350,000 (2001)
Shepherd – 1999	India	15,000 (2004)
ServiPerú – 1996	Peru	94,000 (2003)
Society for Social Services (SSS) – 1996	Bangladesh	27,000 families (2004)
Spandana – 1998	India	390,000 (2004)
Tao Yeu May's Mutual Assistance Fund (TYM) – 1996	Viet Nam	68,000 (2004)
Tata-AIG – 2001	India	13,000 (2005)
Taytay Sa Kauswagan (TSKI) – 2002	Philippines	330,000 (2004)
TUW SKOK – 1998	Poland	93,000 (2003)
L'Union des Mutuelles de Santé de Guinée Forestière (UMSGF) – 1999	Guinea	14,000 (2005)
L'Union Technique de la Mutualité Malienne (UTM) – 1998	Mali	40,000 (2005)
VimoSEWA – 1992	India	120,000 (2005)
Yasiru Mutual Provident Fund – 2000	Sri Lanka	24,000 (2004)
Yeshasvini Trust – 2002	India	1.45 million (2005)

<i>Main microinsurance product</i>	<i>Institutional type/ Delivery model</i>
Credit life and life savings	Credit union association operating insurance scheme for borrowers, risks managed in-house
Various savings and loan-linked covers	Provides technical assistance to an affiliate network of MFIs around the world which all use the partner-agent model; the case study considers the experiences of five MFIs.
Credit life	MFI partnering with a private-sector company, Madison Insurance (partner-agent model)
Health	Public insurance scheme linked primarily to public health-care providers
Health	Public insurance scheme linked primarily to public health-care providers
Health	Public insurance scheme linked to public healthcare providers
Life, livestock, health	MFI partnering with state insurance companies (LIC and UIIC)
Integrated health and funeral	Insurance brokerage partnering with a private insurance company
Health	Healthcare provider and MFI providing insurance in-house
Credit life, spousal death and limited asset loss	MFI offering insurance in-house (self-insurance)
Credit life with hospitalization benefit	MFI offering insurance in-house (self-insurance)
Life insurance, endowment	Private-sector insurance company using partner-agent and micro-agent models
Credit life, life	An OI-affiliated MFI in partnership with Cocolife, a private insurance company
Property, savings completion and AD&D	Mutual insurance company owned by credit union network
Health	Apex body of MHOs
Health	Apex body of MHOs
Integrated life, health and asset	A department of a trade union that has switched between the partner-agent and self-insurance models
Integrated accident, disability, life and health	Unlicensed scheme offering insurance in partnership with NGOs and a network of CBOs
Health	Unlicensed scheme collaborating with state government and cooperatives, benefits only available through a network of healthcare providers

I Principles and practices

What is insurance for the poor?

Craig Churchill

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I Defining microinsurance

Low-income persons live in risky environments, vulnerable to numerous perils, including illness, accidental death and disability, loss of property due to theft or fire, agricultural losses, and disasters of both the natural and man-made varieties. The poor are more vulnerable to many of these risks than the rest of the population, and they are the least able to cope when a crisis does occur.

Poverty and vulnerability reinforce each other in an escalating downward spiral. Not only does exposure to these risks result in substantial financial losses, but vulnerable households also suffer from the ongoing uncertainty about whether and when a loss might occur. Because of this perpetual apprehension, the poor are less likely to take advantage of income-generating opportunities that might reduce poverty.

Although poor households often have informal means to manage risks, informal coping strategies generally provide insufficient protection. Many risk-management strategies, such as spreading financial and human resources across several income-generating activities, result in low returns. Informal strategies for coping with risk tend to cover only a small portion of the loss, so the poor have to patch together support from a variety of sources. Even then, informal risk protection does not stand up well against a series of perils, which unfortunately is a situation often experienced by the poor. Before the household has a chance to fully recover from one crisis, they are struck by another.

Microinsurance is the protection of low-income people against specific perils in exchange for regular premium payments proportionate to the likelihood and cost of the risk involved. This definition is essentially the same as one might use for regular insurance except for the clearly prescribed target market: low-income people. However, as is demonstrated in this chapter and throughout this book, those three words make a big difference.

How poor do people have to be for their insurance protection to be considered micro? The answer varies by country, but generally microinsurance is for persons ignored by mainstream commercial and social insurance schemes, persons who have not had access to appropriate products. Of particular interest is the provision of cover to persons working in the informal economy who do not have access to commercial insurance nor social protection benefits provided by employers directly, or by the government through employers. Since it is easier to offer insurance to persons with a predictable income, even if it is a small sum, than to cover informal economy workers with irregular cash flows, the latter represent the microinsurance frontier.

Microinsurance does not refer to the size of the risk carrier, although some microinsurance providers are small and even informal. There are, however, examples of very large companies that offer microinsurance, such as AIG Uganda, Delta Life in Bangladesh and all insurance companies in India.¹ These large insurance providers have a product or product line that is appropriate for low-income persons.

An important aspect of microinsurance, explored in detail in Part 4, is that it can be delivered through a variety of different channels, including small community-based schemes, credit unions and other types of micro-finance institutions, as well as enormous multinational insurance companies. In fact, Allianz, one of the largest insurance companies in the world, has recently launched an initiative with the United Nations Development Programme (UNDP) and the Gesellschaft für Technische Zusammenarbeit (GTZ) to provide insurance to the poor in India and Indonesia.

Microinsurance also does not refer to the scope of the risk as perceived by the clients. The risks themselves are by no means “micro” to the households that experience them. Microinsurance could cover a variety of different risks, including illness, death and property loss – basically any risk that is insurable.² This book, however, focuses primarily on life and health insurance as demand research across many countries repeatedly identifies illness and death risks as the primary concern of most low-income households (*see Chapter 1.2*).

Often people use the term insurance loosely to refer to general risk-prevention and -management techniques. For example, savings set aside for emergency purposes might be referred to as an insurance fund. This book, however, uses a narrower definition in which microinsurance, like traditional

¹ As described in Chapter 5.2, Indian insurance companies are required to allocate a percentage of their insurance portfolio to persons in the “rural and social sectors”, which in practice means low-income households. Consequently, all Indian insurers are involved in microinsurance in one way or another, so many interesting microinsurance innovations are coming from India.

² Chapters 1.2 and 2.1 describe the characteristics of insurable risks.

insurance, involves a risk-pooling element. Those in the risk pool who do not suffer a loss during a particular period essentially pay for the losses experienced by others. Insurance reduces vulnerability as households replace the uncertain prospect of losses with the certainty of making small, regular premium payments. Yet this risk-pooling function means that insurance is a much more complicated financial service than savings or credit.

Since microinsurance is just one of several risk-management tools available to low-income households, organizations truly concerned about helping the poor to manage risks should assess whether the provision of microinsurance is the most appropriate response. For risks that result in small losses, for risks with high predictability of occurring or high frequency of occurrence, savings and emergency loans would be more appropriate risk-managing financial services. Savings and credit are also more flexible than insurance as they can be used for a variety of different risks (and opportunities). Insurance, on the other hand, provides more complete coverage for large losses than poor households could provide on their own. For these larger risks, participating in a risk pool is a more efficient means of accessing protection than if households try to protect themselves independently.

One must be careful not to overstate the developmental effect of insurance. On its own, insurance cannot eliminate poverty. Yet if it is available to poor women and men along with other risk-management tools, health and life insurance for the poor can make a valuable contribution to achieving the Millennium Development Goals (*see Box 1*).

Box 1

Microinsurance and the MDGs

The Millennium Development Goals, established by the United Nations in 2000, provide more than 40 quantifiable indicators to assess the progress made toward global economic and social development by 2015. The MDGs serve as a development framework, helping to focus the attention of policymakers, donors and development practitioners on the most critical objectives.

Certain MDGs would be more achievable if insurance were widely available among low-income households, including the following targets:

- Halve the proportion of people whose income is less than one dollar per day
- Halve the proportion of people who suffer from hunger
- Ensure that children everywhere, boys and girls alike, will be able to complete a full course of primary schooling
- Eliminate gender disparity in primary and secondary education
- Reduce by two-thirds the under-five mortality rate

- Reduce by three-quarters the maternal mortality ratio
- Halt and begin to reverse the spread of HIV/AIDS
- Halt and begin to reverse the incidence of malaria and other major diseases

For example, insurance can help reduce the proportion of people who suffer from hunger and whose income is less than one dollar per day. While development experts tend to focus on efforts to promote economic development as a strategy to achieve these targets, they have to recognize that gains can quickly be lost when vulnerable households experience a loss or crisis. It is necessary to complement efforts to boost productivity with corresponding efforts to provide protection.

Perhaps even more directly, microinsurance can help address the health-related objectives of reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases. Health microinsurance schemes typically provide immunizations, train birth attendants and make it possible for women to afford transportation and hospitalization for difficult births.

Some microinsurance schemes provide valuable information and resources for risk prevention. By providing education about risks and promoting good health habits, these schemes can reduce incidents of disease and extend life expectancy (*see Chapter 3.9*).

Interestingly, microinsurance can also assist in promoting gender equality and empowering women (*see Chapter 2.4*). If insurance can help protect vulnerable households from falling back or further into poverty, they will be less likely to have to choose which child to send to school. Furthermore, long-term savings and insurance policies enable the poor to accumulate assets that can be used to pay for education, for daughters as well as for sons.

2 The two faces of microinsurance

There are two main varieties of microinsurance – one focused on extending social protection to the poor in the absence of appropriate government schemes and the other offering a vital financial service to low-income households by developing an appropriate business model that enables the poor to be a profitable (or sustainable) market segment for commercial or cooperative insurers.

Yet these two varieties have much in common. One might consider microinsurance like Janus, the ancient Roman god of gates and doors, also the god of beginnings, who is depicted with two faces, yet one body (*Figure 1*). Regardless of whether one is looking at microinsurance from a social-protection or a market-based approach, the body of the insurance scheme, its

basic operations, will be largely the same. Hence a book on microinsurance operations must draw lessons and experiences from both.

Figure 1



2.1 Deepening access to insurance services: A new market

The guru behind the articulation of the “new market” perspective is C.K. Prahalad (2005), who illustrates in his book *The fortune at the bottom of the pyramid* that the “private sector, in its desire to ... gain market coverage, will invent new systems depending on the nature of the market”. Prahalad identifies the more than four billion persons living on less than US\$2 per day as a market opportunity if the providers of products and services, including multinational corporations, innovate new business models and create low-income consumers.

This thinking is certainly not new to those involved in microfinance, where commercialization has been underway since 1992 when the Bolivian microfinance NGO Prodem created BancoSol, the first commercial bank dedicated to serving the low-income market. The creation of BancoSol started a revolution that has inspired at least 39 other NGOs to create regulated financial institutions (Fernando, 2004) and numerous commercial banks and finance companies to reach “down market”.

Besides microfinance, Prahalad also draws examples from other industries, including construction, consumer goods and healthcare. Based on case studies of successful innovations, Prahalad identifies common principles to be considered when innovating for the bottom of the pyramid (BOP). Even though he does not analyse insurance case studies, Prahalad’s “Twelve Principles of Innovation for BOP Markets” are remarkably applicable to the provision of microinsurance (*see Box 2*).

Box 2

Applying Prahalad's "Twelve Principles of Innovation for BOP Markets" to microinsurance

1. *New understanding of price-performance relationship*

Obviously, the poor cannot afford to pay high prices, but that does not mean that they deserve poor-quality products. For microinsurance, it could even be argued that the low-income market requires a *better*-quality product (e.g. quick claims settlements, few if any claims rejections) to overcome their apprehension about paying up-front for some undetermined future benefit. Prahalad also contends that the BOP market is surprisingly brand-conscious, something that microinsurers must keep in mind as they strive to secure the market's trust and confidence.

2. *Combine advanced technologies with existing infrastructure*

Although this is just beginning to emerge in microinsurance, several microfinance institutions are experimenting with technologies, (including ATMs with biometrics, smartcards, palm pilots and point-of-sale devices) to enhance efficiency and productivity. Microinsurers will undoubtedly follow suit.

3. *Scale of operation*

In a BOP business model, the basis for returns on investment is volume. Even if the per unit profit is minuscule, when it is multiplied across a huge number of sales, the return can become attractive to shareholders. This attribute is a perfect fit for insurance and the Law of Large Numbers, whereby actual claims experience should run much closer to the projected claims when the risk pool is larger. When projections can be estimated with a high degree of confidence, then the product pricing does not have to include a large margin for error, making it more affordable for the poor.

4. *Eco-friendly*

Prahalad notes that the resources associated with products in developed countries would be unsustainable if used for the enormous BOP market. Consequently, all innovations must minimize packaging and consider the impact of the product on the environment. This principle may not be directly applicable to microinsurance, however there is a connection. Many catastrophic risks to which the poor are vulnerable are associated with climate change.

5. Requires different functionality

Products and services for the BOP market cannot just be scaled down or less expensive versions of traditional products. With microinsurance, for example, insights into how low-income households might use an insurance payout illustrate key differences with the conventional insurance market. For example, instead of a lump sum of cash, the poor might prefer in-kind benefits (e.g., funeral service, groceries) possibly spread over a period of time.

6. Process innovation

When designing a product for the BOP market, it is necessary to adapt the process as well as the product, taking into account the limited infrastructure typically available for the poor. In microinsurance, for example, one must recognize that the premium is not the only expense. The indirect costs of accessing and using that product, including transportation and the opportunity costs of lost wages, may be much higher than the actual cost.

7. Deskillling work

Service industries are naturally labour-intensive; those focusing on the BOP market are even more so, given the scale of operations. Since labour costs can represent over half of the total operating expenses, one strategy to contain costs is to simplify the operations so that products can be sold and serviced by less expensive workers. Such an approach is quite appropriate for microinsurance because the customers also want simple, easy-to-understand products.

8. Significant investments in educating customers

Prahalad is explicit about the importance of creating BOP consumers through education and the raising of awareness, using innovative mechanisms to reach persons in “media dark zones”. This has also been the experience of microinsurers which need to explain to their clients how insurance works and how they will benefit from it.

9. Designed for hostile conditions

The products and services designed for the BOP market must take into consideration the unsanitary conditions and limited infrastructure (e.g. electricity blackouts, poor water quality). For microinsurance providers, this involves investing in loss-prevention measures such as promoting low-risk behaviour, water purification and hygiene in order to reduce claims for health and life insurance.

10. User-friendly interfaces

The heterogeneous BOP market speaks a myriad of languages with a variety of different literacy levels. Serving this market requires careful consideration to make it easy for poor households to use the service. For microinsurance, the application form should be short and perhaps completed by the sales person. More challenging is the simplification of claims documentation to make it easy for clients to access benefits while protecting insurers from fraud.

11. Distribution

One of the great challenges in serving BOP consumers is to get the product to the market; yet, insurance companies are particularly weak at distribution. The main solution to this problem is to collaborate with another organization that already has financial transactions with low-income households so the insurer can leverage existing infrastructure to reach the poor.

12. Challenge the conventional wisdom

In sum, to serve the low-income market, insurers have to think differently – about customers' needs, product design, delivery systems and even business models. There is a viable market out there if insurers are willing to learn about that market and develop new paradigms for serving it.

To understand clearly how to develop new business models for microinsurance, it is necessary to assess why the current insurance business models do not reach the poor. Although the insurance industry is beginning to notice the vast under-served market of low-income households, insurers have encountered numerous obstacles that need to be overcome if they are to offer microinsurance on a large scale.

Besides the problems associated with high transaction costs and inappropriate distribution systems identified in Box 2, the products generally available from insurers are not designed to meet the specific characteristics of the low-income market, particularly the irregular cash flows of households with breadwinners in the informal economy. Other key product design issues include appropriate insured amounts, complex exclusions and indecipherable legal policy language, all of which conspire against effectively serving the poor.

It is generally assumed that low-income men and women are more vulnerable to risks than the not-so-poor; however, insurers generally do not have data to interpret the vulnerabilities of the poor. To address such a problem, insurers may build in a hefty margin for error and then make adjustments once the claims experience starts rolling in. However, if insurers build

in a cushion on top of the high administrative costs required to serve the low-income market, premiums may not be affordable.

Insurers assume, rightly or wrongly, that the low-income market cannot afford insurance. Interestingly, when insurance first became widespread in the late 19th century, it was seen as a poor man's financial service. The wealthy did not need insurance because they could essentially self-insure. Somewhere along the way, as insurance became more sophisticated and the wealthy recognized their vulnerabilities, the perceptions reversed.

Insurers do not have the right mechanisms to control certain insurance risks, such as adverse selection and fraud, among the low-income market. For example, the claims documentation methods and verification techniques used to ensure that someone with a US\$100,000 life policy is not defrauding the insurer are inappropriate for a US\$500 policy.

A major challenge in extending insurance to the poor is educating the market and overcoming its bias against insurance. Many are sceptical about paying premiums for an intangible product with future benefits that may never be claimed – and they are often not too trusting of insurance companies. Creating awareness about the value of insurance is time-consuming and costly. To be fair, the bias goes in both directions. The people who work for insurance companies are usually unfamiliar with the needs and concerns of the poor. Similarly, the culture and incentives in insurance companies reward salespersons for focusing on larger policies and more profitable clients and portray the idea of selling insurance to the poor as ridiculous.

This low-income market has massive potential if insurers can address these issues with efficient and effective innovations. While these obstacles are significant and daunting, they can be overcome – they are being overcome – by a number of formal and informal insurers around the world that are developing new techniques to reach a vast under-served market.

2.2

Providing social protection for informal workers

Even with significant innovations to insurance business models, product designs and delivery channels, it is clear that not everything or everyone is insurable based on market principles. Nor should that be the case. Indeed, governments have a critical responsibility to provide social protection to their citizens.

Social protection is the other face of microinsurance. It generally includes a variety of government policies and programmes to reduce poverty and vulnerability by diminishing people's exposure to risks and enhancing their capacity to protect themselves. Social protection refers to the benefits that society provides for its members, including:

- unemployment and disability benefits,
- universal healthcare,
- maternity benefits,
- old-age pensions,
- protection for children and the disabled.

However, more than half the world's population is excluded from any type of social security protection, including contribution-based schemes and tax-financed social benefits. In some parts of the world, the situation is particularly severe. In sub-Saharan Africa and South Asia, the coverage of statutory social security is estimated at 5 to 10 per cent of the working population (ILO, 2001).

Developing countries face major challenges in connection with providing comprehensive social protection. The vast majority of persons work in the informal economy, so there are no effective mechanisms to reach them systematically. Since they are self-employed or working in informal businesses, there is no formal employer to make contributions to pension, unemployment or healthcare schemes. Yet, the working poor cannot afford the full cost of social security schemes. At the same time, governments in many developing countries do not have the resources to create sufficient infrastructure (e.g. healthcare facilities) nor pay for the recurring expenses associated with social protection schemes.

Microinsurance as a social protection mechanism strives to fill the gap to provide some coverage for the excluded – which would be even more effective if it were supplemented by government schemes to facilitate a redistributive effect. In the absence of formal social protection, microinsurance responds to an urgent need while not absolving governments of their responsibilities. Indeed, as described in Chapter 1.3, microinsurance can create delivery mechanisms to extend government programmes (and subsidies) to the informal economy, and in so doing integrates the informal and formal social protection systems.

Consequently, regardless of which face of Janus one uses to view microinsurance, the intention is to reduce the vulnerability of the working poor by enticing the public (social protection) and the private sector (new market), or both, to do what neither has so far been particularly effective in doing: providing insurance to the poor. Indeed, since these two faces have the same head, it is reasonable to explore areas of convergence to create alternative models or systems of protecting the poor, such as public-private partnerships, mutuals and cooperatives, and government incentives to correct market failures.

3 What a difference three words make

The operational aspects of extending insurance to low-income households are largely the same, whether one is approaching it from a market or social-protection perspective. The following key characteristics illustrate how insurance for the poor may differ from both conventional insurance and mainstream social-protection programmes:

Relevant to the risks of low-income households

Of course coverage should be linked to the greatest areas of vulnerability for low-income households, but often what is available from insurers or social security administrations does not really address the needs of the poor. Can unemployment insurance really be made relevant for casual day labourers? Do commercial insurers really know what risks poor men and women are most concerned about, what keeps them awake at night?

As inclusive as possible

While insurance companies tend to exclude high-risk persons, microinsurance schemes generally strive to be inclusive. Such an approach makes sense when microinsurance is seen as an extension of government social protection schemes. Indeed, to achieve the social mission of microinsurance, it is necessary to provide protection when vulnerable households need it the most. However, is inclusion feasible for market-based microinsurance? Since the sums insured are small, the costs of identifying high-risk persons, such as those with pre-existing illnesses, may be higher than the benefits of excluding them in the first place. Plus, if microinsurance schemes can reach the tremendous volumes of customers required to achieve the MDG targets, many exclusions and restrictions can be just administrative nuisances that undermine efficiency rather than important insurance risk control tools.

Affordable premiums

At the end of the day, microinsurance schemes have to be affordable for the poor, otherwise they will not enrol in the scheme, nor benefit from the coverage. Various strategies could make microinsurance affordable, including having small benefit packages, spreading premium payments over time to correspond with the household's cash flow and supplementing premiums with subsidies from governments. From the social protection perspective, the redistribution function, from rich to poor, theoretically helps to make contributions affordable for the poorest. In the market model, insurers may be willing to accept low short-term returns, or even losses, to develop the market.

Grouping for efficiencies

Group insurance is more affordable than individual coverage, but how does one find groups of people in the informal economy? Even though the informal economy is sometimes known as the disorganized sector, there are groupings out there that could be used, such as women's associations, informal savings groups, cooperatives, small business associations and the like. Some microinsurers use these groups more effectively than conventional insurers by enlisting the support of the groups in member selection and reducing insurance risks such as over-use and moral hazard.

Clearly defined and simple rules and restrictions

A CEO of a major United States insurance company once admitted that even he did not understand his homeowner's insurance policy. Insurance contracts are generally full of complex conditions, conditional benefits, written in legalese that even lawyers struggle to discern. Although the rationale for the fine print may be consumer protection, if the consumers do not understand what is written, its very object is defeated. Moreover, its content can give the insurance company an excuse not to pay a claim. For a host of reasons, microinsurance has to be kept as simple and straightforward as possible so that everyone has a common understanding of what is and is not covered.

Easily accessible claims documentation requirements

The process for accessing benefits, from social security departments or insurance companies, tends to be so arduous that it discourages all but the most persistent claimants. Such obstacles are inappropriate for low-income households that cannot afford to spend days away from work, paying "unofficial fees" to access official documents. While controls have to be in place to avoid fraudulent claims, for microinsurance to be effective, it has to be easy for low-income households to submit legitimate claims.

Strategies to overcome the wariness of customers

Lastly, microinsurers must have effective strategies to overcome the apprehension of low-income households as regards insurance. One of the primary ways to achieve that objective is through client education, to raise awareness among prospective policyholders about how insurance works and how it can benefit them. Equally important, however, is upholding promises and fulfilling obligations, and creating a culture of insurance among the poor. For microinsurance to build the confidence of the market, it has to avoid many of the common criticisms of insurance providers, who are seen as quick to take one's money, but slow to pay it out. Indeed, microinsurance needs to develop

systems to pay benefits expeditiously, to minimize or avoid claims rejections and to provide a quality of service that earns the trust of a wary market.

For both the social protection and market perspectives, insurance schemes for the poor have to find a way of balancing three competing objectives: 1) providing **coverage** to meet the needs of the target population, 2) minimizing operating **costs** for the insurer and 3) minimizing the **price** (including the transaction costs for the clients) to enhance affordability and accessibility. These represent difficult choices that are best answered by involving those who ultimately benefit from the coverage to choose between them.

In summary, microinsurance must be designed to help poor people manage risks. With that overarching objective forging a unique mindset, microinsurance clearly emerges as quite distinct from mainstream insurance and social protection schemes. Perhaps when they first emerged, both social and commercial insurance were also founded on the ideal of protecting the poor. For example, some of today's large insurance companies began in the 1800s as mutual protection schemes among factory workers. Nevertheless, over the years, efforts to prevent fraud and misuse have created a maze of bureaucratic rules and requirements that undermine their effectiveness and their appropriateness for the poor. In addition, for the market-based approach, efforts to maximize shareholder returns have led them away from their original clientele in search of more profitable customers.

Indeed, microinsurance can be described as an insurance "back to basics" campaign, to focus on the risk-management needs of vulnerable people, and to help them manage those risks through the solidarity of risk pooling. Although not all microinsurance schemes are true to these values, the closer they can come, the more likely they will benefit the people who need them the most.

1.2

The demand for microinsurance

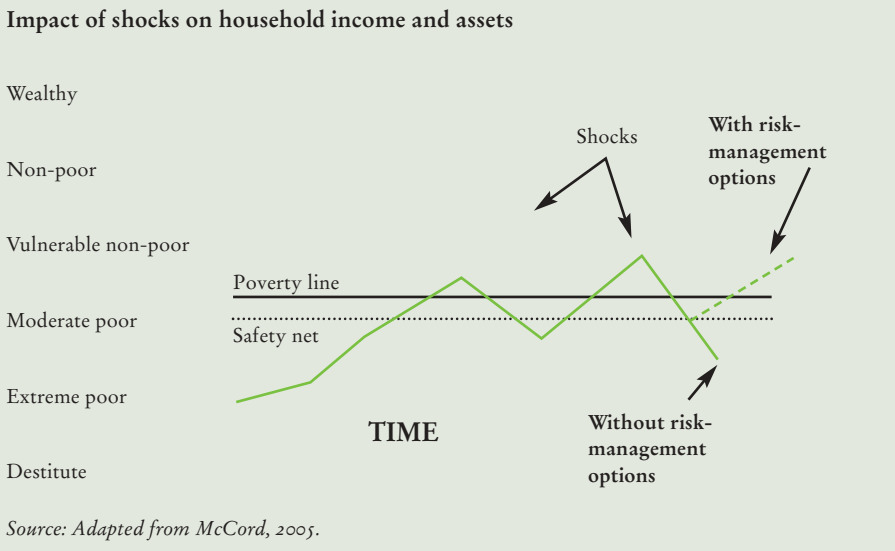
Monique Cohen and Jennefer Sebstad

The authors appreciate the insights and comments of Frank Bakx (Rabobank Foundation), Michal Matul (Micro Finance Center) and Michael McCord (MicroInsurance Centre).

Risk is ever present in the lives of the poor. Faced with shocks, poor people draw on their financial, physical, social and human assets to meet the resulting expenses. In the absence of precautionary or ex ante risk-management instruments, most are forced to rely on a range of options after the fact or ex post. When a crisis occurs, a common coping strategy is to borrow from the moneylender or microfinance institution; others might ask friends and relatives to help. Few have access to formal insurance services.

Poor people struggle endlessly to improve their lives. It is a slow and gradual process marked by tentative advances. Continually bombarded with financial pressures, low-income households find that shocks can easily erode their hard-earned gains. The result is that their trajectory out of poverty follows a zigzag route: advances reflect times of asset building and income growth; declines are the result of shocks and economic stresses that often push expenditure beyond current income (*Figure 2*). The role of microinsur-

Figure 2



ance, like any effective risk-management instrument, is to temper these downturns, which are major impediments to escaping poverty. Confronted with a shock, poor people usually patch together a variety of resources, including formal and informal credit and savings, and seeking out additional work or income-generating opportunities to meet their expenses. Understanding these risk-management strategies is a starting point for thinking about the demand for insurance by the poor. This chapter explores the risks to which low-income people are vulnerable, analyses their primary means of coping with or managing these risks, and provides insights into how insurance could enhance the ability of the poor to deal with risks.

I Managing risk

I.1 Shocks and stress events

Vulnerability is closely associated with poverty and can be described as the ability of individuals and households to deal with risk.¹ The demand for microinsurance is directly related to vulnerability; it grows out of the risks and risk-management strategies of low-income households. Research on the impact of risk events and on how poor people cope with shocks helps illuminate the demand for insurance.

Risk comes in many forms, for example illness, death of a loved one, fire or theft. These shocks occur frequently and create pressures on household cash flow that exacerbate the ever-present stress of meeting regular expenses, such as food, rent and school fees. When financial pressures exceed the cash-flow capacity of the household, people must seek finance from outside sources. In some circumstances, microinsurance could be an option for filling this gap.

The difference between microinsurance and conventional insurance policyholders is that the former are poorer, have fewer financial reserves and have incomes that fluctuate considerably throughout the year. The poor are more vulnerable to such shocks because they have fewer resources not only to meet the immediate costs of the shock, but also the secondary expenses incurred in getting back on their feet (*Box 3*). Once their reserves are depleted, low-income households are forced into increasingly reactive modes of behaviour. They respond to each crisis with increasingly stressful coping mechanisms (*Figure 3*). The challenge for microinsurance is to turn reactive risk-management practices into proactive ones.

¹ Risk is defined as the chance of a loss or a loss itself.

Box 3

Impact of shocks on the rich and poor in Viet Nam

Shocks that are minor for the non-poor can be devastating for those below the poverty line. In Viet Nam, the poor and rich can experience the same illnesses. However, compared to the wealthy, the poor tend to get sick more often, and therefore the costs are higher both in absolute terms and relative to household income. They also face difficult trade-offs: high health costs can also leave people with no money to send their children to school.

Source: Adapted from Tran and Yun, 2004.

1.2

Prioritizing risks

While across countries and in different markets within countries people prioritize risk differently, low-income households consistently identify the loss of a household income earner or sickness of a family member as their greatest concerns (*Table 2*). Disability is also important but often subsumed under health. These shocks include both those that can be anticipated and those that cannot. Fortunately, many of the prevalent risks lend themselves to protection through insurance.

Table 2

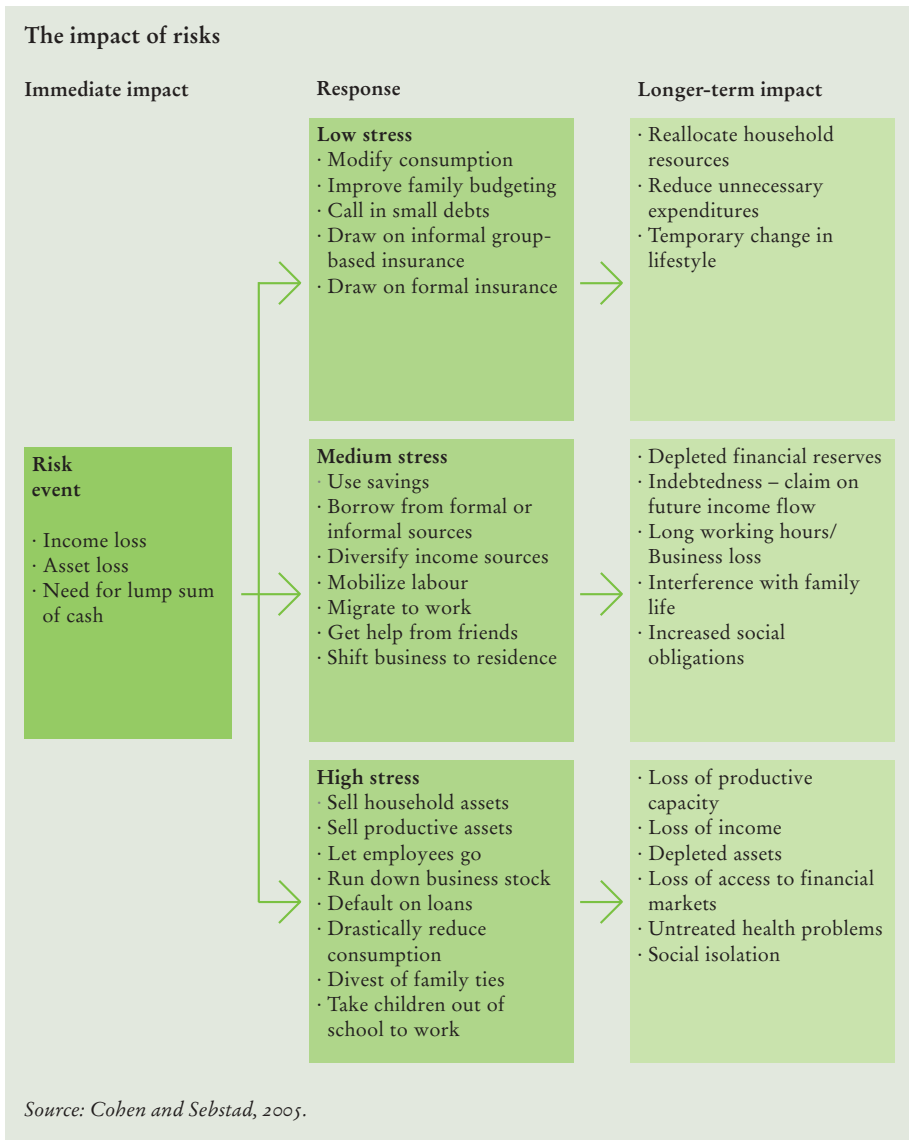
Priority risks in selected countries

Country	Priority risk
Uganda	Illness, death, disability, property loss, risk of loan
Malawi	Fear of death, especially in relation to HIV/AIDS, food insecurity, illness, education
Philippines	Death, old age, illness
Viet Nam	Illness, natural disaster, accidents, illness/death of livestock
Indonesia	Illness, children's education, poor harvest
Lao P.D.R.	Illness, livestock disease, death
Georgia	Illness, business losses, theft, death of family member, retirement income
Ukraine	Illness, disability, theft
Bolivia	Illness, death, property loss including crop loss in rural areas

Sources: Enarson and Wirén, 2005; Matul, 2004; Matul and Tounitsky, 2006; Mekong Economics, 2003; McCord, 2005; McCord et al., 2005b; Sebstad and Cohen, 2001.

While the dominance of illness is not surprising, it is easy to lose sight of its double impact in terms of the loss of income and added expenses. For families with sick children, small expenses can quickly mount up and have huge financial impact. Accidents, as well as chronic illness such as malaria and HIV/AIDS, require extremely large sums. These overwhelming financial pressures frequently fall on women, many of whom assume primary responsibility for the welfare of their families.

Figure 3



2 The importance of understanding the demand for microinsurance

Initial forays by insurance companies into the low-income insurance market have focused on downscaling existing formal insurance products. In the absence of market research, microinsurance providers have given limited attention to the match between products and consumer preferences. The result has been the supply of products that are not always well suited to the market. With this have come low persistence and renewal rates.

Improved understanding of demand enhances the design of appropriate products and identifies the steps that should be taken to ensure the adoption of these products by the poor. Market research improves the uptake of these unfamiliar services by determining what types of insurance low-income groups need, what types they can afford and what products it is feasible to deliver.

The range of topics for microinsurance demand research can be broad, depending on the intended use of the findings and the time and resources available. Research can be carried out at three levels, each dealing with a particular aspect of market demand: 1) understanding client needs, including their current risk-management behaviour, 2) product-specific research and 3) an analysis of the overall potential market.

The first level focuses on **understanding client needs** and what risks it makes sense to insure for different groups among the poor. It involves research on:

- key risks facing poor people,
- the impact of these risks,
- existing coping mechanisms,
- the effectiveness of the coping mechanisms,
- the role microinsurance (or other financial services) can play.

This level of research emphasizes current risk-management behaviour. Information on current practices and financial strategies households use to prepare for and respond to shocks helps to identify the vulnerabilities of the target market. A focus on existing coping mechanisms, and specifically group-based informal insurance mechanisms that involve risk pooling, can help to identify positive attributes of informal insurance systems that could be incorporated into the design of more formal microinsurance products. Understanding coping strategies can help to separate out risks that might be better addressed through savings and emergency loans. This type of research translates core needs into actual products by generating information that can be useful in identifying appropriate product attributes, such as the type and

amount of coverage, exclusions, delivery models, premium amounts, premium payment options, premium collection procedures and claims procedures.

The second level, **product-specific research**, can be carried out in conjunction with the development and testing of a product prototype and/or the actual delivery of an insurance product. Demand research on existing products, best undertaken after a product has been on the market for a while, addresses issues of customer satisfaction and loyalty. The focus is on people's adoption of the product, generating information that can be used in the design, delivery and affordability of new products or the refinement of existing ones. Emphasis is placed on the extent to which products match the needs, preferences and income capacity of low-income people (Sebstad et al., 2006).

The third level of research addresses the **size of the potential market** for a particular microinsurance product.² It estimates the number of potential policyholders in a particular geographic setting with potential demand and the capacity to pay. Of key importance is segmenting the market by particular types of insurance and estimating the incidence of the risk event for a particular population in a defined geographic location and within a specified time period. This information relates to the financial feasibility of an insurance product, the number of subscribers required for the product to be profitable, and pricing as well as other dimensions of a product within a market.³ This level can also address current use and knowledge of insurance, attitudes towards insurance concepts and the insurance sector. Research on these issues helps to determine the potential market over the short and medium term. It also identifies those segments of the market that have specific usage and attitude problems with respect to microinsurance. This information can be used to formulate strategies to attract potential policyholders.

3 Current coping strategies: Strengths and weaknesses

In coping with shocks and stress events, precautionary measures are desirable but not always possible, especially for low-income households. Options for protecting against risks ahead of time may include:

- diversifying income sources,
- building assets by saving money, stocking food and investing in housing and healthcare,
- strengthening social networks,

² The authors are indebted to Michal Matul for his contribution to this section.

³ This includes promotion, positioning, place, people and process.

- participating in reciprocal borrowing and lending systems, welfare associations and other informal group-based insurance systems,
- enrolling in formal insurance or pension schemes or other formal social security systems,
- managing money well by controlling consumption and maintaining access to multiple sources of credit.

All of these options are widely used; however, when cash flow is limited, poor households often manage shocks and stress events *ex post* (see Box 4).

Box 4

Risks and risk management in Malawi

People in Malawi are very much aware that improving the health of individuals and animals is the best precaution against disease. However, in this very poor country, the lack of both health and veterinary services and access to appropriate financial services is an obstacle. In addition, Malawians find that the lack of transport and poor communications also restrict their capacity to cope with risk.

Source: Adapted from Enarsson and Wirén, 2005.

The options for coping with losses *ex post* are both extensive and creative. Some long-standing, informal and self-insurance risk-management tools have been adapted over the years to respond to new diseases such as HIV/AIDS, new pressures such as the privatization of the health system and changes in the financial services market. Aspects of each can work for low-income households, although the levels of coverage and effectiveness will vary depending on the option. Few low-income households limit themselves to one risk-management instrument. They mix and match various options depending on the risk, the loss and their cash flow (see Box 5).

Box 5

Coping strategies in Viet Nam

In Viet Nam, loans are often used for healthcare. Sales of pigs, important assets, are often used to pay expenses such as school fees. Cash savings can be important, but they are limited. Cash kept at home is risky because of the continual pressure on its use. Next in importance is saving in a group, like a rotating savings and credit association (ROSCA), even though this is seen primarily as a precautionary mechanism.

Source: Adapted from Mekong Economics, 2003.

As illustrated in Table 3, both *ex ante* strategies (precautionary) and *ex post* strategies (managing a loss) for dealing with risk generally involve a mix of intra-household measures (self-insurance) and inter-household, group-based measures (informal and formal insurance). The types and mix of strategies an individual or household uses at any given time will reflect its level of vulnerability. The pros and cons of these risk-management instruments are discussed below.

Table 3

Coping strategy by risk			
<i>Coping strategies</i>	<i>Risks</i>		
	<i>Death</i>	<i>Health</i>	<i>Property</i>
Self-insurance	Financial services Money lender	Financial services Current income Family/friends Sell/pledge assets Money lender Reduced consumption	Financial services Current income Sell assets Precautionary measures
Informal group-based mechanisms	Welfare associations (funeral societies) ROSCAs	Welfare associations Borrow from church groups Fund raisers ROSCAs	Welfare associations Vigilante groups Hiring of guards
Formal insurance	Partnerships between insurers and MFIs	Partnerships between insurers and MFIs purchase health insurance	Partnerships between insurers and MFIs purchase property insurance
Social protection		Health services Disability compensation	Police

3.1 Self-insurance

Self-insurance, which does not have a risk-pooling mechanism, is a common risk-management strategy for people at all income levels. For example, economic stresses that cause a short-term increase in household expenses can often be mitigated with credit, savings or additional income. Generally these mechanisms work best in situations where risks have a high probability of occurring and cause relatively small losses.

Drawing on savings is less expensive than using credit for expected needs. Yet, this savings strategy also is limited. Many poor households have difficulty amassing sufficient funds to manage risks adequately. Those that have sav-

ings are reluctant to draw on them as they strive to preserve these hard-earned assets for earmarked purposes, such as investing in a business or building a house (Sebstad and Cohen, 2001). A study in Tanzania found that many people with significant savings prefer to borrow rather than draw on these savings when faced with an unexpected demand (Millinga, 2002). In Bolivia, many of the urban poor borrow as an instant response to a crisis. (Velasco and del Granado, 2004). By contrast, in South Africa, savings play a key role in risk management (Bester et al., 2004).

In general, credit is ill suited for larger losses, such as expensive healthcare shocks and catastrophic events that affect large numbers of people at the same time. Protection against these losses requires other forms of social protection, disaster assistance or public support (Churchill, 2005; Siegel et al., 2001). One area where credit has proved effective in managing risk is through emergency loans, such as those introduced by CIDR in Mali. A highly popular financial product in rural areas, the funds are tapped to overcome a common hurdle in accessing healthcare, i.e. the need to pay for transport to a medical centre. Ensuring access to multiple sources of microcredit in an emergency is another risk-management strategy, but there are limitations. Clients in the middle of repaying one loan may not be allowed to borrow extra funds from the same source. They are also at risk of assuming more debt than they can handle (*see Box 6*).

Box 6**Risk management and over-indebtedness in Georgia**

Research from Georgia shows that the most common risk-management strategies involve excessive borrowing and the liquidation of household assets. Over the long run, increasing over-indebtedness and a shrinking household asset base increases a household's vulnerability to poverty. This is a particular phenomenon in transition countries where the new poor, slow to develop their own coping strategies, still expect inefficient governments to help them.

Source: Adapted from Matul, 2004.

Borrowing from family and friends is widely acknowledged as a strategy for meeting unanticipated shocks. However, the amounts of money are usually small and not always available, especially when prospective benefactors experience the same crisis. The source of support also comes with expectations of reciprocity, which can create longer-term pressures.

When people respond to a crisis by borrowing, repayments place a claim on future income. If income dips, households may be forced to mobilize labour (including children), sell assets or go even further into debt. Defaulting on the loan is rarely perceived as a viable option. The poor generally go

to great lengths to maintain their access to microcredit, if only to be assured access to a lump sum in future times of need (Sebstad and Cohen, 2001).

Depletion of assets is a last resort. With it goes the loss of the household's productive base and capacity to generate future income. When productive assets are sold, resuming productive activities is much more difficult and stressful. As observed in Albania, crises often require selling productive assets and inventory at great discounts to pay expenses and debt. The household is then doubly punished when it seeks the money to repurchase the assets. Repeated shocks combined with depleted reserves to reduce the household's ability to resume productive activities, recover and cope with future risks (Szubert, 2004).

People also self-insure through other precautionary measures. In East Africa, shopkeepers invest in burglar bars on windows and night watchmen; alternatively, they sleep in their shops or simply take their inventory home with them (Cohen and Sebstad, 2005).

3.2 Informal group-based mechanisms

Low-income households in many countries use diverse types of welfare associations for sharing risk (*Table 4*). Their underlying basis is reciprocal exchange in times of need. Ethnically or geographically based welfare associations help their members manage cash flow or pool risk. Many are governed by well-defined charters and require payment of dues in return for the right to access group resources, in cash or in kind, for a specified need.

Table 4

Examples of informal group-based insurance systems

Country	Name of welfare association	Function
Uganda	<i>Munno mukabi</i> (friends in need)	Covering funeral requirements including food for guests and embalming of the body
Philippines	<i>Damayan</i>	Welfare/burial societies
South Africa	Funeral or burial societies ⁴	Emotional support, helping hands
Indonesia	<i>Arisans</i>	Health insurance

When a death occurs, welfare associations are particularly adept at responding quickly. A major weakness can be the limited coverage provided

⁴ Funeral or burial societies are distinct from funeral parlours, which deal with the body, and from funeral insurance, which provides cash support, although some funeral parlours offer insurance with an in-kind benefit.

by a single burial society; also a series of shocks can deplete its reserves. As a result, households often belong to multiple associations and incur the high transaction costs that accompany each membership (*see Box 7*).

Box 7

Membership in multiple burial societies

In South Africa, people willingly hold numerous policies, because each may be insufficient or provide different funeral coverage. Membership of numerous welfare associations is also common. The first is intended to cover the funeral costs, the second to provide food for the children and the third one is for the secondary impacts, to keep food on the table, keep the children in school and help the household recover.

Source: Adapted from Bester et al., 2004.

Households sometimes fall out of informal group-based funeral societies in their communities because they are socially excluded or too poor to participate. In the absence of this support, life insurance is often a more important need than among those who are not socially or economically excluded.

Informal group-based mechanisms also include ROSCAs and accumulating savings and credit associations (ASCAs), which are used as a way to save. Depending on the size of the cash contribution, they can be useful when a relatively large amount of cash is needed. However, these mechanisms may not be sufficiently flexible to provide the funds when they are most needed, since members often need to wait their turn. In Indonesia, members faced with an emergency can apply to take their turn early, but receive only a discounted amount (McCord et al., 2005b). In situations where the ROSCA mechanism is not sufficiently responsive to emergencies, however, membership of such a group often creates social capital on which the members can draw in times of need.

3.3

Formal insurance

Microinsurance is a new option for low-income households. Designed primarily to provide protection for health and death expenses, these new products so far have met with varying degrees of success. Poor individuals and households at or around the poverty line are the primary target market. Those households well below the poverty line are most in need of insurance, but it may be unaffordable for them.

The most common form of microinsurance is credit life. As discussed in Chapter 2.3, it is common in credit unions and other MFIs for the outstanding balance of a loan to be covered should a client die. While credit life can be a good source of revenue for an MFI, policyholders often question the value

of the credit-life product and see the primary purpose as being to protect the lender, not the borrowers.⁵

Funeral insurance (*see also Chapter 2.3*) is popular, especially in countries where the high cost of burials or funerals can put a family heavily into debt (*see Box 8*).

Box 8

High cost of funerals in Zambia

Madison Insurance in Zambia has developed a funeral insurance product that is distributed through MFIs. Since funerals in Zambia can cost between US\$300 and US\$500 (the GDP per capita is US\$900), this was a welcome addition to the financial services offered to the poor. In the words of one client: “Thandizo (the insurance product) is one of the best services I have received from Pulse (one of Madison’s MFI agents). For the insured members of my house, I am assured I will not have to struggle to meet funeral costs, and my business income is spared.”

Source: Adapted from Manje, 2005.

In some parts of Africa and elsewhere, women are especially vulnerable following the death of a husband when they lose their property to other relatives (in the absence of property rights or knowledge of ways to exercise their property rights). For many women, their priority is life insurance for their husbands. In the event of their own death, women fear that their husbands may use an insurance payout intended for the children’s education to invest in a new wife. Increasingly, women prepare for their own death by designating their friends as beneficiaries and instructing them to use the money for the children’s school fees and other necessities (Cohen and Sebstad, 2005).

Health insurance is in high demand, but difficult to deliver (*see Chapter 2.1*). Households want comprehensive coverage, but often lack both the capacity to pay and access to quality services. As rural Nepalis noted, “in the absence of good health services, paying for health insurance is simply a waste” (Simkhada, et al., 2000). Furthermore, as discussed in Chapter 1.3, the role of the state in the provision of health insurance cannot be ignored. It will continue to be important in determining the likely role of health insurance in many countries.

Despite its potential, the effective demand for microinsurance is still unclear. Many microinsurance products are bundled with loans, and the

⁵ There is considerable support for this argument. The number of claims paid annually is usually very small. In addition, many MFIs set age ceilings for borrowing, ensuring that clients are out of the programme before they become high death risks.

premium is included as a fee paid at the time of loan disbursement. This has two effects: 1) people are often unaware of how much they are paying and what they are actually paying for and 2) when clients stop borrowing, they generally lose their insurance coverage.

3.4 Social protection

For many of the working poor, government health services could be an option to cover health and disability risks. However, many poor households prefer private services to low-quality public healthcare. Indeed, with low-income households bearing as much as 80 per cent of their health costs in some countries, many poor people see an obvious opportunity for microinsurance (McCord, 2005).

In transition countries, the decline of universal social protection has left a different gap and opportunity for microinsurance. Despite the declining role of the state in the provision of healthcare, people's behaviour has lagged behind. Few households budget for their health expenses (Matul, 2006).

Governments have a role in allocating funds to protect the destitute and those with no ability to generate sufficient funds for risk management. Private insurance will never be an option for this market.

4 Opportunities for microinsurance

In deciding where microinsurance can most effectively fit into the mix of risk-management strategies, it is first necessary to determine which risks best lend themselves to insurance. The ICMIF test for an insurable risk suggests one approach (*Table 5*).

The next question is where microinsurance can add value for the client. The above review suggests that managing risk is currently an ex post rather than an ex ante activity for low-income households. Self-insurance is the most common risk-management option, but its effectiveness is limited because it generally covers only a small portion of the loss. This has a negative effect on income and assets in the short term, and on the capacity to manage future risks in the longer term. People often get by with great difficulty, trying to stay one step ahead of the next crisis. By increasing the portion of the loss covered, insurance could meet a need and reduce the stresses associated with poverty.

Table 5

Test for an insurable risk

- | | |
|--|--|
| <input type="checkbox"/> Does the loss occur by chance? | <input type="checkbox"/> Will the risk pool attract sufficient numbers of clients who are unlikely to submit claims (does it meet the criteria for adverse selection)? |
| <input type="checkbox"/> Is the loss definite in time and amount? | |
| <input type="checkbox"/> Does the loss create significant hardship relative to income? | <input type="checkbox"/> Is the loss a genuine loss to the insured (no house, no house insurance)? |
| <input type="checkbox"/> Are a large number of similar units exposed to the risk? | <input type="checkbox"/> Is the loss one that will not be catastrophic to the insurer? Does the same risk affect more than one person or household at a time? Is it idiosyncratic? |
| <input type="checkbox"/> Is it possible to estimate the possibility of the loss occurring? | |

Source: ICMIF, 2005.

Analysts of demand data need to be discriminating in interpreting the findings. While poor people experience many risks and their coping mechanisms are imperfect, this does not necessarily translate into demand for insurance. Experience with informal group-based insurance is not always transferable to microinsurance. For example, according to McCord and Buczkowski (2004), even though the members of CARD MBA in the Philippines participate in *damayan*-type schemes, they have little knowledge of formal insurance concepts and products.

The review of risk-management strategies provides insight into the product attributes that might be integrated into the design and delivery of microinsurance products. This section considers six aspects of insurance demand: 1) coverage, 2) accessibility, 3) timeliness, 4) pricing and affordability, 5) client education and 6) market segmentation.

4.1 Coverage

Health coverage is a top priority for low-income households in most countries. The most common insurance products available to the poor include life and funeral insurance. On a smaller scale, there are initiatives concerned with health protection, livestock, crop and property insurance.

While the level of coverage varies for different products, typically no single form of insurance provides full coverage to low-income households. Many clients would prefer more coverage, but cannot afford it. In South Africa, where funeral insurance is available, the cost of funerals is most often covered by income, savings, borrowing and gifts, in that order. Insurance benefits, in cash and in kind, come fifth and sixth and account for less than 20 per cent of the expenses (Financial Diaries, 2005).

Even with access to insurance, low-income households will continue to cover the costs of shocks from a mix of financial services, i.e. formal, informal and self-insurance. In developing insurance products, it is important to recognize the complementarities among different financial services, as well as different institutional providers of social protection, to see how they might work together to better manage risks.

While disability risk is covered by some policies, insurance usually provides a one-off payment rather than a replacement for loss of income or salary. Thus, only a part of the loss is covered. This creates high stress for the working poor when health risks affect their ability to earn income.

Flexible schemes that offer different levels and types of coverage provide people with more options, but can be more complex to administer and require more client and staff education. Coverage levels and product features, especially policy exclusions, are rarely explained or fully understood by the target market. For example, in Uganda, policyholders' lack of knowledge about the insurance product was consistent across the MFIs that offer coverage backed by AIG Uganda. Many were not aware of all of the product's benefits, and they often did not distinguish between family members covered by the policy and the person who is to receive the cash payout if the policyholder dies by accident. They considered all of them as beneficiaries of insurance (McCord et al., 2005a).

4.2 Accessibility

Self-insurance is the only option open to everyone. Group-based informal insurance depends on trust and reciprocity, features that also have been important to the success of solidarity group lending. Access is closely associated with being part of a social network. The groups provide the basis for risk pooling and a platform for administering regular contributions and payouts. Membership in a group is an important way that poor people build social capital and access informal insurance. The extent to which existing groups might provide an institutional base for expanding the outreach and access to microinsurance is unknown. Some mutual health schemes have pursued this route (*see Chapter 4.3*).

The ability to obtain birth and death certificates or identity cards also affects the accessibility of microinsurance. Providing claims documentation can be even more challenging for poor people in remote areas where bureaucratic systems do not function well, or in areas where civil conflict affects the security and mobility of people. Complex payment and claims processes can also affect accessibility. Formal insurance is frequently plagued with claim payout problems. The claims process is often too complex and impersonal

for people whose previous experience with risk-management instruments is with their communal welfare associations.

To date, MFIs have played an important role in developing microinsurance and making it accessible to low-income groups. The advantage is their outreach to the poor. One limitation, however, is that not all types of insurance are relevant to the interests of the MFI (in terms of reducing arrears). Another limitation is that microinsurance policies for many microcredit providers are linked to their loans and therefore available only to their clients. If microinsurance is to be open to all low-income households, it is essential for credit and insurance to be de-linked and for the payment of the premium to be separate from the disbursement of loans.

4.3 **Timeliness**

By definition, low-income households are vulnerable to shocks because they lack cash reserves to cover immediate expenses. Consequently, the timeliness of claim payments is crucial for product adoption. People in eastern and southern Africa prefer welfare associations because they require little or no paperwork to verify a death, and payouts can be immediately available. In contrast, claim payments by insurance companies can take months.

4.4 **Pricing and affordability**

Evidence shows that demand for microinsurance is high and there is a willingness to pay. In some countries, people are particularly interested in insurance that is coupled with asset building. In Indonesia, for example, the first priority is an insured savings product for education, with payouts made as needed to cover selected school fees (McCord et al., 2005b).

With microinsurance consumers increasingly discerning and heterogeneous, there is a need for premium payments to be structured in ways that make sense to the policyholders. As discussed in Chapter 3.3, insurance providers would do well to match the premium payments to the cash flow of low-income households. In this respect, informal mechanisms have proven more responsive to client needs than many current microinsurance providers. For example, in Albania, Opportunity International found that an existing insurance product failed not because the terms and pricing were unacceptable, but because the premium had to be paid in advance. The up-front payment requirements were not in line with the potential policyholders' cash flow (Leftley, 2002).

So what is the capacity to pay? This is difficult to determine. As Matul and Tounitsky (2006) have noted, this is not only a function of income levels but also very subjective. The level of financial literacy strongly influences what people think they can afford; client education on the insurance product influences what people think they are getting for the price.

There is mounting evidence that some policyholders are very sensitive to the value of the costs and benefits of a microinsurance policy. Across three countries in West Africa, CIDR found that the contribution of household income to health insurance is consistently between 1.5 and 2.5 per cent of household income. When the premium price is raised above 2 per cent, households adjust by reducing the number of household members covered by insurance, rather than increasing their premium payments (Galland, 2005a). In Ukraine, market research showed that a decrease in the premium by 30 per cent was met by a 10 per cent increase in policyholders (Matul, 2006). Indeed, market research is critical to better understand ability and willingness to pay (*see Box 9*).

Box 9

Understanding the demand for microinsurance in Sri Lanka

Yasiru policyholders in Sri Lanka found that the benefit payments were not proportionate to premiums that they were paying and that the insurance policy did not clearly define the number of family members covered. An assessment of client preferences led to policy adjustments to ensure that premiums better matched benefits and the relationship between premiums and the number of family members covered was clearer.

Source: Adapted from Fokoma, 2004.

Poverty limits the number of financial obligations a person can take on. Experience from an MFI-linked insurance scheme in Nepal suggests that many poor households find the burden of an insurance premium on top of a loan repayment to be a strain. Policyholders who already had health insurance were unwilling to pay a second premium for voluntary life insurance (CMF, 2005). However, the mandatory nature of many insurance products makes it difficult to predict the demand (and willingness to pay) among poor households for voluntary insurance at different premium levels.

4.5

Insurance education

Risk management by the poor is not new, but for many people insurance as a risk-mitigation instrument is. As a result, its adoption presents a challenge to clients and sales agents. Among those who have heard about insurance, there is considerable scepticism. For many low-income households, insurance is

seen as the province of the rich. Indeed, confidence in the insurance industry is often low and negative perceptions abound. There is a reluctance to pay in advance for services one may not receive, especially an intangible service that one may not even understand. For those who have had experience with insurance or have heard about the experiences of others, the limited scope of coverage and the long delays in settling claims exacerbate the negative perception. In some cultures, it is not always socially acceptable to bet on negative events: any focus on illness and death is seen as wishing for bad luck.

If microinsurance is to succeed, there is a vital need for strategic investments in consumer education to change these perceptions. The knowledge and attitudes of low-income households and insurance agents need to be improved. While some organizations selling microinsurance give potential policyholders information describing the premium, benefits and claims procedures, this has limited value if the policyholders – and often the insurance agents – lack a basic understanding of insurance and risk management. As illustrated in Box 10, many poor persons are interested in learning more about insurance.

The success of microinsurance adoption is not simply a function of making certain that products are appropriate and affordable, but is also dependent on a level of financial literacy that enables consumers to assess what they are getting when they pay a premium. Changing the consumer's knowledge, skills and attitudes toward insurance, and creating an insurance culture, are important in facilitating the adoption of this formal financial service.

Box 10

We want to know more ...

1. Malawi

While the MUSCCO members were aware of insurance, they did not necessarily know what an insurance policy was. They wanted more information about insurance, including its costs and benefits (Enarsson and Wirén, 2005).

2. Uganda

Most policyholders did not know how much they were paying, what was covered or how to make claims. The insurance agent (an MFI staff person) also knew little and therefore could rarely be of much help (Cohen and Sebstad, 2005).

3. Guatemala

Columna policyholders said that they wanted to be better informed, but the institution failed to provide them with more information (Herrera and Miranda, 2004).

4.6 One size does not fit all

Demand research shows that generalizing across countries and regions is risky when considering the attributes of risk-managing financial services. One size does not fit all. For example, in Nepal and Indonesia there is limited demand for life and funeral insurance as funeral expenses are kept at a level that the family can afford (Simkhada et al., 2000; McCord et al., 2005b). By contrast, life and funeral insurance are very much in demand in Uganda and South Africa. In both countries, there are high levels of expenditure on the rites associated with funerals; meanwhile traditional systems of community support have been under a lot of stress, especially in regions affected by HIV/AIDS (Sebageni, 2003; Bester et al., 2004).

Demand studies also reveal different insurance priorities for different market segments. The one-size-fits-all approach that characterizes the design of many life insurance products does not typically consider differences in gender, location or life-cycle position of the policyholder. For example, for poor middle-aged women, life cover for their spouses is likely to have a higher priority than cover for their own lives.⁶ SEWA Bank clients in India made this point and were successful in securing life insurance policies for their husbands even though the bank manager assumed they would find it unaffordable. As alternative delivery channels are used to reach the working poor, such as those described in Chapters 4.5 and 4.5, other market segments will be reached, bringing a demand for different products or product features.

The experience of low-income households illustrates the importance of complementary activities across different market segments, not only to mitigate losses resulting from insurable risks (e.g. loss of life), but also to help build and protect assets – thereby strengthening the longer-term capacity of households to manage risks. Stress events such as weddings, payment of school fees and housing expenses often exert great financial pressure, especially for women. Insured savings or endowments offer potential solutions. These endowment products, offered by insurance companies in Indonesia, Bangladesh and Ghana, for example, have proved popular among the poor (though less so in Sri Lanka). They build assets while protecting people against potential losses. However, they are not without the risks associated with long-term macroeconomic and corporate stability, and may not be the most cost-effective way for the poor to manage risks (*see Chapter 2.2*).

⁶ Many microfinance borrowers fit this profile, but the MFI's rules may require her to leave the programme at 55 or 60, at which time she will stop contributing to life insurance and her children will no longer receive benefits should she die. Under these circumstances, what does she have to gain from a life insurance policy?

5

Conclusion

The growing number of demand studies is beginning to provide a credible base of information which can be used to estimate market demand and help design appropriate products in selected countries. This is enabling service providers to move away from simply downsizing existing insurance products originally aimed at the middle class to developing products and services that work for the “bottom of the pyramid”.

The market for microinsurance is large. All stakeholders, insurance companies, their agents and policyholders have much to gain from this market being served well. However, getting everyone working together will take time. In the absence of a strong insurance culture among low-income households, client demand in many places is still evolving. Where insurance has worked well for low-income households – where the coverage is appropriate, accessible, affordable and well understood – it has been met with considerable and growing success. It reduces risk and vulnerability in the lives of poor people, allowing them to move from reactive to proactive behaviour and thus plan for the future. With more financial control, poor people have more options. Research on client demand can continue to play a key role in the development of successful microinsurance products.

1.3

The social protection perspective on microinsurance

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*The authors appreciate the comments provided by Bruno Galland (CIDR)
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I

Introduction

Access to social security is a fundamental human right. Moreover, social security and social protection are increasingly recognized in the global debate as indispensable components of poverty reduction, sustainable economic development, fair globalization and decent work. In this respect, the World Commission on the Social Dimension of Globalization stresses that a minimum amount of social protection must be accepted as being an integral part of the socio-economic base of the global economy. Social protection is also a key tool for the attainment of the Millennium Development Goals (MDGs).

Therefore, social protection is much more than a risk-management instrument for individuals. It is a comprehensive, collective tool to reduce poverty, inequality and vulnerability. It promotes equity and solidarity through redistribution. And it provides fair access to healthcare, income security and basic social services. However, more than half of the world's population does not benefit from any form of social protection.

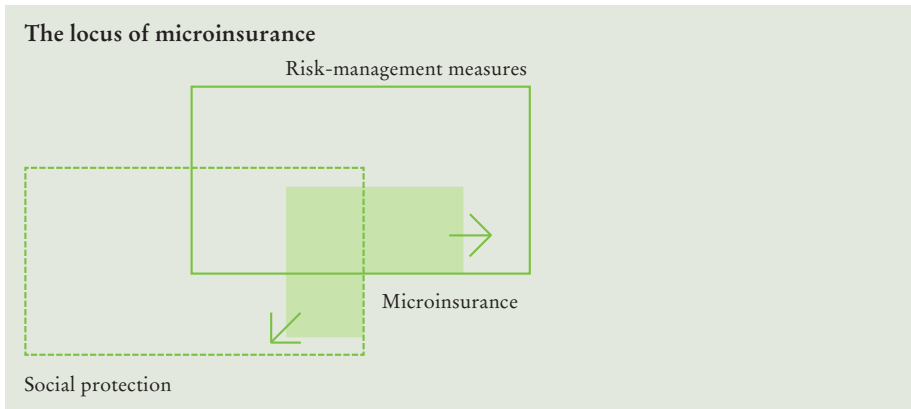
Facing exclusion from social protection, local communities are taking initiatives to organize microinsurance schemes. Microinsurance is delivered through a diversity of organizations covering various risks or contingencies including health, maternity, life and disability. Some schemes are not just risk-management instruments, but have the potential to contribute to the extension of social protection to excluded groups. Furthermore, these schemes can improve the governance of social protection providers (e.g. healthcare) and raise supplementary resources that enhance social protection as a whole. This is particularly necessary where the state has limited financial and institutional capacity.

¹ This chapter is adapted from a forthcoming publication by the ILO and GTZ entitled *The role of microinsurance as a tool to face risks in the context of social protection*. Examples from Senegal are drawn from the authors' experiences.

Microinsurance schemes can be components of social protection systems, as illustrated in Figure 4, although this has several implications:

- Microinsurance schemes may assume some social protection functions, such as redistribution through internal cross-subsidies or by channelling public subsidies to their members.
- Microinsurance schemes should not only be evaluated on technical aspects (e.g. financial viability), but also on their capacity to reach social protection outcomes; the socio-economic impact of these schemes on members and non-members should be taken into consideration.
- A non-regulated market may fail to provide an efficient benefit package for the poor.
- Microinsurance schemes can play an important role in the empowerment and participation of their members, which has implications in terms of the design of the products, the choice of the benefit package, affordability and the organization of the schemes.

Figure 4



However, stand-alone, self-financed microinsurance schemes have major limitations on their ability to be sustainable and efficient social protection mechanisms capable of reaching large segments of the excluded populations. Their potential to extend social protection is increased when governments include them in national social protection strategies, linking them to other social protection components to create a progressively more coherent, efficient and equitable system.

This chapter explores the relationship between social protection and microinsurance by first defining social security and social protection. Within that context, the chapter then defines microinsurance, and goes on to illustrate its potential and limitations. Finally, it provides some illustrations of how microinsurance can be used to extend social protection to excluded populations and to overcome some of the inherent limitations.

2 What is social security? What is social protection?

2.1 Definition, objectives and key functions

According to the ILO (2000), **social security** is the protection which society provides for its members through a series of public measures:

- to compensate for the absence or substantial reduction of income from work resulting from various contingencies (notably sickness, maternity, employment injury, unemployment, invalidity, old age and death of the breadwinner),
- to provide people with healthcare,
- to provide benefits for families with children.²

Social protection includes not only public social security schemes but also private or non-statutory schemes with similar objectives, such as mutual benefit societies and occupational pension schemes, provided that the contributions to these schemes are not wholly determined by market forces.

This definition of social protection is one of several approaches. Other organizations, such as the World Bank and the Asian Development Bank, use more holistic conceptions of social protection (“social risk management”). They include a larger range of contingencies – anything that affects individuals’ income security – which naturally overlaps with other sector policies, such as education or labour. This broader view not only includes protecting mechanisms, but also promotional interventions to increase assets or economic opportunities (such as microfinance programmes, price supports or commodity subsidies). Indeed, the concepts of social protection are still under discussion, for example in the Network on Poverty Reduction facilitated by OECD’s Development Assistance Committee.

Regardless of the specific definition, social protection is an important tool to prevent poverty and strengthen the capacity of the poor to get out of poverty. For instance, some social protection measures consist of a direct transfer of funds to the poorest (identified through means testing), which has

² The ILO has a number of social security conventions that deal with the practical implementation of this human right. The most important is the Social Security (Minimum Standards) Convention, 1952 (No. 102). It defines nine branches of social security and the corresponding contingencies covered: medical care, sickness benefit, unemployment benefit, old-age benefit, employment injury benefit, family benefit, maternity benefit, invalidity benefit and survivors’ benefit. In addition, it introduces the idea of a minimum level of social security that must be achieved by all member states. To take into account different national situations, ILO conventions on social security typically contain flexibility clauses regarding the population covered, and the scope and level of benefits provided. They also give states full discretion in the organization of their social security scheme. In other words, these conventions affirm the right of everyone to social security, but recognize the practical difficulties in actually implementing this right in the social realities that prevail worldwide.

a direct and at least temporary effect on poverty. Social protection also reduces poverty through its positive impact on economic performance and productivity. It can be seen as a productive factor for three main reasons (ILO, 2005b):

1. Social protection helps people to **cope with important risks** and loss of income. In doing so, it can enhance and maintain the productivity of workers and create possibilities for new employment. For instance, healthcare systems help maintain workers in good health and cure those who become sick. Similarly, work injury schemes help prevent accidents and sickness and rehabilitate injured workers.
2. Social protection can be a critical tool in **managing change in the economy** and the labour market. For instance, unemployment insurance creates a feeling of security among the workforce, which encourages individuals to undertake riskier initiatives that may result in a higher return for them and for the economy.
3. Social protection can **stabilize the economy** by providing replacement income that smoothes out consumption in recessions, thus preventing a deepening of recessions due to collapsing consumer confidence and its negative effects on domestic demand. For instance, unemployment benefits and old-age pensions help to maintain the purchasing power of workers after they have lost their jobs or retired.

Social protection can enhance principles such as solidarity, dignity and equality. **Solidarity** arises when everyone contributes to a common pot according to their capacity and draws from this pot according to their needs (within the limits fixed by the internal rules of the scheme). Solidarity can also materialize through the redistribution of funds raised through taxes. The level of solidarity depends on the nature of the financing instruments that are being used: while income tax or income-related contributions are usually progressive, consumption taxes or flat-rate premiums run the risk of being regressive.

Social protection is linked with the principle of **dignity** since it gives people the right to live a decent life whatever adverse events afflict them. Unlike charity, social protection integrates individuals in a process of exchange, where they have the right to receive and the obligation to give. Their dignity is recognized by allowing people the possibility to contribute. Social protection is also linked with the principle of **equality** (including gender equality) and non-discrimination when equal rights are given to all people exposed to the same risks or supporting the same burdens without discrimination.

The application of the principles of solidarity, dignity and equality within

social protection help to foster social cohesion, inclusion and peace, which are prerequisites for stable long-term economic growth. Furthermore, the integrative role of social protection brings individuals or groups that have been excluded into the mainstream by providing support in accessing employment and becoming active, and possibly tax-paying, members of society (Piron, 2004). Social protection can finally be a tool to promote empowerment and participation through the representation of workers in the formal economy (within statutory social protection schemes) and informal economy (within community-based social protection schemes). This participation is one way of enhancing democracy.

The ILO's conception of social protection (definition, functions) is shared by many institutions worldwide. Recently, the most important international federations and organizations representing the cooperative and mutual insurance sector formed the International Alliance for the Extension of Social Protection.³ Their shared vision, values and principles are articulated in "the Geneva Consensus" 2005, which recognizes that "social security is a fundamental and universal human right". This consensus also enumerates basic principles and values regarding social protection – such as solidarity, redistribution, role in economic and social development, importance of efficiency, relevance, good governance and financial viability – and suggests that the values of the cooperative and mutualist movement be held in high regard (e.g. social justice, absence of exclusion and discrimination, non profit, participation and empowerment).

2.2 Gaps between right and reality

The definition of social security as a human right starts from the principles of universality and equality: every human being is equally entitled to social security, which has two major implications.

1. States have an obligation to take measures to guarantee this right.

They have to take appropriate legislative, administrative, budgetary, judicial or other measures to ensure that the right is guaranteed to their populations. This obligation does not necessarily mean that the state has to provide social protection directly; it can facilitate or encourage actions of third parties. Obligation can be of conduct: states have to take the necessary steps to guar-

³ The members include: ISSA (International Social Security Association), AIM (Association Internationale de la Mutualité), ICA (International Cooperative Alliance), ICMIF (International Co-operative and Mutual Insurance Federation), IHCO (International Health Co-operative Organization), WIEGO (Women in Informal Employment: Globalizing and Organizing) and the ILO. For more details about the International Alliance, see www.social-protection.org.

antee a particular right. Obligation can also be of result: states have to achieve specific targets to satisfy a specific standard. In addition, there is an obligation of the international community, so far unofficially recognized, to support states with insufficient resources to guarantee human rights, including the right to social security. This is in line with the idea behind the Global Fund for Malaria, Tuberculosis and HIV/AIDS.

2. *Everybody is entitled to a minimum level of social protection, without exception or discrimination.* This entitlement includes an equitable access to social protection, independent of individuals' age, sex, health status, location, occupation or income level. This entitlement to a minimum level of social protection is often used to justify the design and implementation of equity subsidies from the rich to the poor.

Yet in many developing countries, social protection coverage is dramatically low: it reaches only a small proportion of the population and provides protection against only a limited range of risks. In sub-Saharan Africa and South Asia, only 5 to 10 per cent of the population is covered by a statutory social security scheme, primarily old-age pension schemes and access to healthcare (ILO, 2001). In some countries, the percentage of the population covered is even shrinking due to structural adjustment policies, privatization and the development of the informal economy. Although some excluded people work in the formal sector, the vast majority are active in the informal economy.

Until the last decade, social protection strategies were based on the assumption that the formal economy would progressively gain ground on the traditional economy, and therefore social security would progressively cover a larger proportion of the workforce. However, this has not happened. In many developing countries, most of the jobs created during the last decade have been in the informal economy (ILO, 2002a). Today, informal employment comprises one half to three quarters of non-agricultural employment in developing countries. If informal employment in agriculture is included in the estimates, the proportion of informal employment increases significantly, for example from 83 to 93 per cent in India, from 55 to 62 per cent in Mexico, and from 23 to 34 per cent in South Africa (ILO, 2001). Although some states have tried, so far attempts to extend the coverage of statutory social security to workers in the informal economy have been insufficient.

2.3 Priority to extend social protection coverage

It is therefore necessary to find other ways to translate the right to social protection into reality. At the International Labour Conference in 2001, governments and employers' and workers' organizations representing 160 countries agreed upon a new consensus on social security; they agreed notably that highest priority should be given to policies and initiatives to extend social security to those who have none, and they proposed several ways of accomplishing that objective:

When these groups cannot be immediately provided with coverage, insurance – where appropriate on a voluntary basis – or other measures such as social assistance could be introduced and extended and integrated into the social security system at a later stage when the value of the benefits has been demonstrated and it is economically sustainable to do so. Certain groups have different needs and some have very low contributory capacity. The successful extension of social security requires that these differences be taken into account. The potential of microinsurance should also be rigorously explored: even if it cannot be the basis of a comprehensive social security system, it could be a useful first step, particularly in responding to people's urgent need for improved access to healthcare. Policies and initiatives on the extension of coverage should be taken within the context of an integrated national social security strategy (ILO, 2001).

At the suggestion of the Conference, in 2003 the ILO launched the “Global Campaign on Social Security and Coverage for All”.

When faced with the present situation where a large (and growing) number of persons are excluded from social protection, it is necessary to devise proactive strategies to extend it. These strategies aim at increasing the number of persons covered and at improving the level and the scope of existing social protection benefits. A range of mechanisms can be used to implement these strategies, for instance:

- Social insurance schemes can extend existing or modified benefits to previously excluded groups, on either a compulsory or a voluntary basis. The inclusion of these groups may also enhance the schemes' effectiveness through improved governance and design.
- Special social insurance schemes can be set up for excluded groups.
- Universal benefits covering the whole target population without any condition or income test (for instance, those over a certain age) can be implemented.

- Social assistance programmes targeting specific vulnerable groups can also be implemented: waivers, social pensions/cash benefits, conditional cash transfers (for instance on school attendance).
- A complementary option is to encourage and support the development of microinsurance and innovative decentralized social security schemes to provide social protection through communities, social partners⁴ or other civil society organizations.

3 What is microinsurance?

As described in Chapter 1.1, a microinsurance scheme may be an organization, like a mutual benefit society. It could also be a set of institutions working together, such as insurers that collaborate with microfinance institutions to provide insurance to the poor. Or it could be an insurance product provided by an organization that conducts other activities, like an agricultural cooperative that also provides insurance to its members.

Microinsurance schemes are often initiated by civil society organizations. Increasingly, these organizations cooperate with formal social protection schemes (e.g. insurance companies, social security schemes), public institutions (e.g. departments of health, labour and social affairs), service providers (e.g. healthcare providers, third party administrators (TPAs)). Sometimes even municipalities or local authorities are involved in offering microinsurance.

For a scheme to be of interest in the context of social protection, some of its beneficiaries should be excluded from formal protection schemes, in particular informal-economy and rural workers and their families. A microinsurance scheme differs from programmes that provide statutory social protection to formal workers. Membership is not compulsory (but can be automatic). The members contribute, at least partially, the necessary premiums to pay for the benefits. Since their capacity to contribute is often low, the coverage provided by these schemes is – in the absence of subsidies – usually limited, with a small number of risks covered and low levels of benefits.

As discussed in the previous chapter, workers in the informal economy and their families typically request coverage for illness and death; the demand for protection against other risks is less widespread, although it can be significant in certain markets (e.g. the demand for livestock and crop coverage in rural areas). In terms of availability, not all microinsurance products are present in all countries. Some products may be well-established in one

⁴ The ILO is a unique forum for governments to interact with employers' and workers' organizations, otherwise known as social partners. In the ILO's tripartite governance structure, employers' and workers' organizations have an equal voice with governments in shaping its policies and programmes.

region, but almost non-existent in another. For example, life microinsurance is seldom found in western Africa, whereas it is relatively developed in some Asian countries.

According to inventories of microinsurance schemes conducted in 2003/2004 in 11 African countries, India, Bangladesh, Nepal and the Philippines (ILO/STEP, 2003/2004):

- health microinsurance is predominant in Africa (100 per cent of investigated schemes) and the Philippines (70 per cent of the schemes provide health insurance); it ranks second in India (56 per cent of schemes) and Nepal (52 per cent), and is less important in Bangladesh (39 per cent);
- life microinsurance is most common in Bangladesh (72 per cent of investigated schemes provide life insurance), the Philippines (66 per cent) and India (60 per cent); it is less available in Nepal (38 per cent); and
- examples of crop microinsurance were found only in India (two schemes in 2004); pension schemes were only seen in India (4 per cent of investigated schemes) and the Philippines (24 per cent).

4

Potential and limitation of microinsurance as a social protection mechanism

Not all microinsurance plays a role in extending social protection. Some products – such as asset, livestock and housing microinsurance and credit-linked insurance that only covers the outstanding loan balance – though certainly beneficial, do not provide social protection coverage in the strict sense. In contrast, other products, such as health, life, old-age pensions and disability covers address the nine contingencies specified in ILO's Social Security Convention (No. 102) and therefore play a role in the extension of social protection.

4.1

Positive contribution of microinsurance in the extension of social protection

Where governments have limited financial and institutional capacity, microinsurance schemes may raise supplementary resources (finance, human resources, etc.) which benefit the social protection sector as a whole. More specifically, health microinsurance schemes help to improve access to healthcare by lowering the financial barriers that delay or impede access. In some cases, the quality of care is even improved, for example when the schemes sign agreements with healthcare providers on the quality of delivery. Con-

tracting with healthcare providers also increases transparency in billing practices and the way the health sector is managed.

Microinsurance also has several positive effects on the participation of civil society and the empowerment of socio-occupational groups including women. For example, since many schemes are set up and operated by women's associations, they may strengthen women's capacity to meet their health needs including those linked with their reproductive role.

Moreover, microinsurance as a mechanism to extend social protection has the following comparative advantages over classical social security schemes:

1. Microinsurance can reach groups excluded from statutory social insurance, such as workers in the informal economy and rural workers.
2. The transaction costs necessary to reach these populations may be reduced, since microinsurance schemes are often operated by decentralized civil society organizations, often relying on voluntary self management, that are implemented in the vicinity of the target population.
3. Microinsurance benefits are often designed in partnership with the target population. This participation is highest in mutual benefit associations where the benefit package is voted on by the general assembly. In other types of schemes, the target groups are usually consulted, for instance through household surveys. As a result, microinsurance often responds to the target population's needs and ability to pay.
4. Community-based schemes usually experience fewer problems with fraud and abuse than centralized social protection systems since members often know each other, belong to the same community and share the same interests. However, community-based schemes can have difficulty collecting regular contributions, resulting in retention problems and sustainability challenges. Some schemes manage this issue of low renewals through group insurance contracts with organized occupational groups (such as cooperatives).

The development of microinsurance is ongoing, with a proliferation of new schemes, especially in India. For example, ILO/STEP (2004) found 60 microinsurance schemes covering 5.2 million people. The inventory is being updated; the current (early 2006) number of schemes stands at 71 covering more than 6.8 million people in India and 240 microinsurance schemes covering 25 million people in 8 countries of Asia. This suggests that these schemes respond to a real demand and that they manage to solve a certain number of issues, at least at the local level.

4.2 **Current limitations of microinsurance as a mechanism of extension of social protection**

Despite these apparent advantages, certain characteristics of microinsurance schemes limit their contribution to the extension of social protection:

1. Although microinsurance is becoming more common, many persons excluded from legal social protection schemes are still not covered by microinsurance either. In fact, many of these schemes (particularly in Africa) have great difficulty extending their geographic or socio-occupational outreach and increasing their membership.
2. Many microinsurance schemes have poor viability and sustainability. These two points are linked (particularly in Africa) with poor management skills (not enough financial resources to employ professional staff) and inadequate information systems, which makes it difficult to monitor the scheme's operations.
3. Members' ability to pay is most often very low, which leads also to limited benefits in the absence of subsidies.
4. Most schemes do not take over the functions that are usually fulfilled by statutory social security schemes – such as redistribution between richer and poorer segments of the population – because contributions are often based on a flat rate. In addition, few schemes reach the poorest segments of the excluded groups who cannot contribute.
5. In many countries, the legislative framework and regulations are not adapted to these schemes and do not facilitate their replication and expansion.
6. Microinsurance schemes are usually self-governing organizations. They may pursue objectives that are not in line with government's strategy of social protection and their promoters may be unwilling to participate in national systems of social protection, as this could threaten the schemes' autonomy.

5 **How can microinsurance be used to extend social protection?**

An increasing number of states consider microinsurance as a tool for the extension of social protection, and include this mechanism in their extension strategies. In several countries, microinsurance schemes are already part of the process of implementing progressively more coherent and integrated social protection systems:

- In India, the prescribed use of the partner-agent model (see Chapter 5.2) increases the acceptance of insurance by the target groups;
- In Senegal, microinsurance schemes are mentioned in the national social protection strategy as a key mechanism to extend social protection;
- In Rwanda and Ghana, the State implements nationwide social protection schemes in health that are built on district- and community-based mutual organizations.
- In Colombia, the government provides subsidies that enable the poor to be purchasers of health insurance, which even stimulates competition to serve the low-income market by microinsurance providers and others (*Box 11*).

Box 11

The extension of social protection through microinsurance in Colombia

As a part of the reform of the healthcare system in Colombia in 1993, a special scheme (Régimen Subsidiado de Salud) was introduced to finance healthcare for the poor and vulnerable groups (including their families) who are unable to pay contributions to the general insurance scheme.

The funds are raised through a solidarity contribution collected under the contributory social insurance scheme and various state subsidies. They are then channelled to several institutions, including 8 mutual benefit associations federated in a national apex organization Gestarsalud, which now covers 60 per cent of the market, “cajas de compensación” (20 per cent of the market), and several private commercial insurance companies that also cover 20 per cent of the market. Today this successful subsidized scheme covers 18.5 million people.

Source: Adapted from Pérez, 1999.

There are three ways to overcome the limitations mentioned above. First, further development of microinsurance is required to increase the population covered, enhance the benefits package and strengthen the capacities of the schemes. Second, linkages need to be developed with other players and institutions. Third, microinsurance needs to be further integrated into coherent and equitable social protection systems.

5.1 The further development of microinsurance

The further development of microinsurance has implications for various actors, including the promoters and operators of the schemes, as well as the state.

For microinsurance promoters and operators, this further development may mean altering the way the schemes currently operate. Management must become more professional to enable the schemes to deal with the increasing complexity of meeting the needs of the target group. One way of doing that is to outsource some management functions to specialized organizations. It may also mean setting up new schemes targeting the members of large organizations such as trade unions, cooperatives and occupational associations. Larger schemes are in a position to provide more comprehensive coverage, particularly against major risks like hospitalization, and they are often more sustainable as they can more easily build up financial reserves.

As described in Chapter 5.3, the state may also support the development of microinsurance through promotion and the sensitization of public opinion (particularly the target population). Other government measures might include:

- building the capacity of microinsurance schemes through improved management and monitoring systems,
- strengthening the viability and the financial capacity of the schemes, for example through reinsurance or guarantee funds,
- supporting structures like second-tier associations or networks that provide technical support and training to microinsurance schemes,
- facilitating the exchange of information between actors to make sure that successful experiences can be replicated with other groups or in different geographic areas,
- formulating recommendations on design: benefits package, affiliation, administration, methods of payment to healthcare providers and
- establishing structures to produce information (statistics, indicators) that can be used by these schemes to price their products more accurately.

5.2

The development of linkages

A key strategy to strengthen microinsurance schemes and compensate for some of their weaknesses is to link them to other organizations, institutions or systems. Table 6 provides a few examples, classified according to the types of mechanisms used and the possible partners.

Table 6

Typology of microinsurance linkages

<i>Mechanisms</i>	<i>Actors/partners</i>
<ul style="list-style-type: none"> - Subsidies (local, national, international) - Contracting with healthcare providers - Outsourcing management functions - Technical advice - Financial consolidation (reinsurance, guarantee funds) - Distribution of insurance products - Distribution of public goods (immunization, HIV/AIDS treatments and testing, social assistance) - Bargaining - Exchange of information, practices - Regulation, control 	<ul style="list-style-type: none"> - Other microinsurance schemes, federations of schemes - Civil society organizations, mutuals, MFIs, trade unions, cooperatives, associations, etc. - Service providers, e.g. healthcare, TPAs - Private sector, pharmaceutical industry - Central and local governments - Public health programmes - Social assistance programmes, cash transfers - Social security schemes, private or public insurers - International cooperation

The sharing of functions or responsibilities according to each party's core competences may create complementarities, economies of scale and make the schemes more efficient. Examples of linkages include: Yeshasvini in India outsources management functions to a TPA (*see Chapter 4.6*); formal insurance companies in many countries distribute products through community organizations (*see Chapter 4.2*); the creation of economies of scale and bargaining power through the grouping of microinsurance schemes, as in the case of emerging African federations (*see Chapter 4.3*); and channelling subsidies through mutual benefit associations in Colombia (*Box 11*).

Functional linkages may also be established with other components of social protection to improve the coherence of the national system of social protection. Examples of such linkages include channelling social services to eligible members and distributing social insurance (*Box 12*).

Box 12

Linkages in the Philippines

The Philippines Health Insurance Corporation, or PhilHealth, has a mandate to achieve universal coverage by 2012. One of the paramount challenges is to provide health insurance coverage to workers in the informal economy, which is estimated at 19.6 to 21.7 million workers or between 70 and 78 per cent of the employed population.

In response to this challenge, PhilHealth approved a resolution in 2003 to allow partnerships with organized groups on a pilot basis. The partnership, called PhilHealth Organized Group Interface (POGI), is seen as an innovative approach to reach out to workers in the informal economy through

cooperatives. The initiative is being tested with eleven cooperatives that conduct marketing and collect premiums for PhilHealth.

Source: Adapted from GTZ-ILO-WHO, 2005.

A critical linkage to achieving social protection objectives is with health-care providers. The decentralization of the healthcare sector may facilitate contractual arrangements between microinsurance schemes and healthcare providers at the local level. To ensure that these relationships are mutually beneficial and effective, however, it may be necessary for the government to intervene (*Box 13*).

Box 13

Developing balanced linkages in Senegal

In Senegal, most mutual health organizations sign contractual agreements with healthcare providers. However, the relationship is often unbalanced and the mutual has no real means of compelling the healthcare provider to respect its commitments.

To face this problem, the Ministry of Health recognized the need to design a national contracting policy and framework that gives guidelines and concrete tools to facilitate the contracting process, including stages in the design of an agreement, minimum content of an agreement, commitments of both parties (including financial aspects, invoicing and payment methods), monitoring tools and procedures, and the State's role. A working group was created in 2006 to design a first draft of this framework that will then be presented to the relevant stakeholders for their feedback.

As illustrated in *Box 11*, mechanisms to redistribute subsidies can help microinsurance schemes provide a minimum package of social protection to poorer households or individuals with low contributive capacity or high social risks (e.g. the elderly, the chronically ill, certain occupational groups). Such mechanisms provide an equitable access to social protection independently of individuals' characteristics and financial capacity. Beside their redistribution role, these subsidies also make the beneficiary microinsurance schemes more attractive, which helps bolster their membership. Since redistribution at a national level may not be sufficient for poor countries, it is also useful to consider international redistribution (*Box 14*).

Box 14

The Global Social Trust

The mission of the Global Social Trust is to systematically reduce poverty in developing countries through a partnership that invests in and sponsors the development of sustainable national social protection schemes for people and

groups that have been excluded from the economic benefits of development. The basic idea is to request people in richer countries to contribute on a voluntary basis a modest monthly amount (say 0.2 per cent of their monthly income) to a Global Social Trust that will be organized in the form of a global network of national trusts supported by the ILO. The Trust will invest these resources to build up basic social protection schemes in developing countries and sponsor concrete benefits for a defined period until the schemes become self-supporting. For more information, see: <http://www.ilo.org/public/english/protection/socfas/research/global/global.htm>

5.3 Integration into coherent and equitable social protection systems

Providing social security to citizens remains a central obligation of society. Through legislation and regulations, governments are responsible for ensuring that the public has access to a certain quality of services. This does not mean that all social security schemes have to be operated by public or semi-public institutions. Governments can delegate their responsibility to organizations in the public, private, cooperative and non-profit sectors.

What is needed, however, is a clear legal definition of the role of the different players in the provision of social security. These roles should be complementary, while achieving the highest possible level of protection and coverage. For example, a social security development plan would define the scope and coverage of services through government agencies, social insurance, private insurers, employers and microinsurance schemes. In this context, governments and social partners should explicitly recognize microinsurance as a social protection tool and integrate it into national strategies of social protection, health development and poverty reduction (e.g. PRSPs in Senegal). The role of health microinsurance in an overall health financing policy coordinated by the State should be recognized as well. The overall aim of such a policy is universal access to healthcare based on pluralistic financing structures (*Box 15*).

Box 15

Cambodia's Master Plan

In Cambodia, the government recognizes the potential of social health insurance as a major healthcare financing method. To reach universal health coverage, Cambodia's Master Plan for Social Health Insurance recommends a parallel and pluralistic approach which comprises: (1) compulsory social health insurance through a social security framework for public and private sector workers and their dependants, (2) voluntary insurance through the development of community-based health insurance schemes and (3) social assistance

through the use of equity funds and later government funds to purchase health insurance for non-economically active and indigent populations.

Source: Adapted from WHO Cambodia, 2003.

The design and adoption of appropriate legal frameworks is a key step towards this integration. Such a framework may specify the role of microinsurance in the social protection system and introduce a set of rules and institutions for the supervision of microinsurance schemes. Legislative frameworks can contribute to the development of these schemes, although frameworks with high financial requirements or intensive supervision from the public authorities may restrain their development. To strike an appropriate balance, ILO/STEP is supporting the construction of a regional framework in eight UEMOA (*Union économique et monétaire d'Afrique de l'Ouest*) countries to design and implement legislation to regulate mutual benefit organizations and support their development.

For microinsurance promoters, the integration into social protection systems has various implications. The benefits package that they provide should include coverage against one or more of the contingencies listed in Convention 102. Moreover, when a minimum guaranteed package of social protection has been defined by the legislation, these schemes should provide this coverage to all their members. Microinsurance schemes' internal regulations should abide by the principles of equity defined by legislation (if any). Rules such as the exclusion of members over a certain age or calculation of premiums based on individuals' risks may not be in line with such principles. If microinsurance schemes receive public financial support, they should be accountable for the efficient use of these public funds. This implies that strict rules of management and accounting be enforced. Microinsurance schemes should also agree that their financial statements be supervised by a public or independent regulatory body.

More generally, it is important that promoters and operators of microinsurance be involved – either directly or indirectly through federations representing their interests – in national consultations and negotiations with the state and other stakeholders in the design and implementation of national social protection strategies. Such integration needs a climate of trust and confidence between operators of schemes, networks of schemes, other civil society organizations representing the populations covered by these schemes (trade unions, cooperatives, etc.) and the government (*Box 16*).

Box 16

An integrated approach to social protection in Senegal

In Senegal, many actors have contributed to accelerate the process of extending social protection, including the State, local governments, social partners and other civil society organizations, donors and healthcare providers. Several events have been significant:

- In 2003, the law on mutual health organizations was adopted; a national framework on the development of MHOs was created, as was the national committee on social dialogue.
- In 2004, the global campaign on social security and coverage for all was launched in Senegal. The trade union of transport operators included social protection issues in its platform. In addition, a law was adopted to design and implement a social protection scheme for rural workers (*Loi d’Orientation Agro-Sylvo Pastorale*).

These events have been integrated in the logical framework of the national strategy for the extension of social protection and risk management (SNPS/GR) formulated in 2005 with the active participation of a large number of players. This strategy aims at extending social protection from 20 to 50 per cent of the population by 2015 through new schemes designed to respond better to the priority needs of informal-economy workers.

These events and the national strategy formulation led in 2006 to feasibility studies to design and establish two nationwide social protection schemes, one for transport operators and their families (target population of 400,000 people) and the other for rural workers and their families (target population of 5 million people).

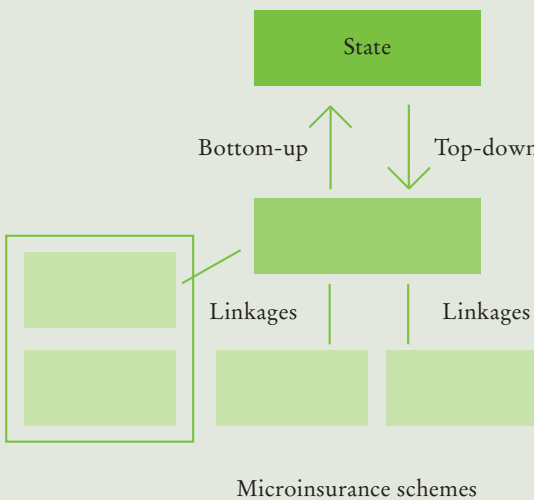
6 Conclusion

Microinsurance is one instrument which can be used to extend social protection to the excluded. It is particularly relevant in situations where governments lack the resources and capacity to provide social protection. Even in situations where the resources are available, if governments support microinsurance as a social protection mechanism, like in Colombia, it may be a more efficient means of social protection than services provided entirely by the government. For microinsurance to achieve its potential, and overcome its limitations, it requires a dynamic, three-pronged approach, as illustrated in Figure 5:

- **Bottom-up initiatives:** To stimulate the grassroots development of microinsurance, it is necessary to sensitize the general public, policymakers, donors and development agencies, as well as social partners and other social protection actors, about how microinsurance works and its potential contribution to social protection.
- **The development of linkages** with government interventions, other microinsurance schemes, healthcare and other service providers, social security institutions, social assistance programmes, etc. can strengthen the sustainability of the schemes as well as enhance their effectiveness.
- **Top-down efforts:** To fulfil its social protection potential, microinsurance must be seen by policymakers and other stakeholders within the broader context of coherent national social protection systems or strategies.

Figure 5

A dynamic approach to extending social protection through microinsurance



As an independent risk-management arrangement, microinsurance is not sufficient to protect poor people against risk. An integrated strategy of social protection should be conceived in collaboration with the government, the private sector, health professionals, social partners and other civil society organizations. Microinsurance can be most successful if it complements other risk-management instruments on the basis of a comprehensive risk assessment.

Although the operations of microinsurance schemes are largely the same regardless of their objectives, microinsurance schemes in the context of social protection should be assessed and monitored differently from microinsur-

ance schemes for assets, livestock or housing, for example. The social protection schemes have to be inclusive of high-risk or destitute members, and ideally access public subsidies to compensate for the higher claims or lower contributions. If they access public subsidies, they also have to be accountable for them, ensuring that those funds are used efficiently and for the intended purposes.

The decision to implement or support microinsurance schemes is not only driven by a risk analysis, but also by political considerations: priority contingencies to cover, populations to be targeted, the relevance of this mechanism as compared to others, and the possibility to link it to other mechanisms and other social protection components. The objective is to improve efficiency, increase coverage and progressively create more coherent and equitable systems of social protection.

2 Microinsurance products and services

Challenges and strategies to extend health insurance to the poor

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Health insurance has several peculiarities that distinguish it from other types of coverage, such as life and property. This chapter reviews the specific characteristics of health microinsurance, paying special attention to the different points of view of insurance providers and the insured.

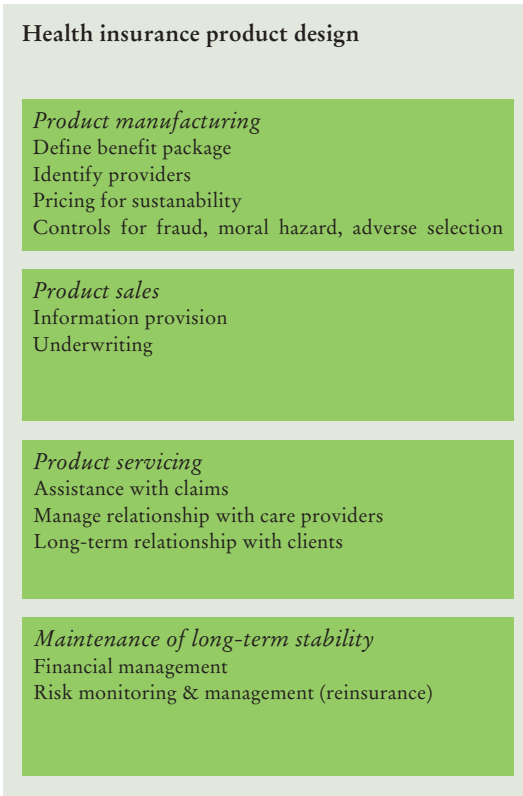
Talking about health microinsurance requires, firstly, agreement on the definition. This chapter defines health insurance as a risk-transfer mechanism under which the insurer assumes a certain risk on behalf of the insured in exchange for a premium. The premiums are paid in advance in return for compensation paid retrospectively if an insured event occurs. Health insurance defines the insurable risks in terms of cost-generating health events. Health *micro*insurance implies that the premium charged is appropriate for low-income clients; this in turn results in severe rationing of benefits to maintain viability. When the benefits of a product are rationed, they need to be tailored to the needs of different market segments.

The tailoring issue is important as exposure to risk differs, for example, between miners, farmers, fishermen and market vendors, to name but a few occupations. Those working in the fields often walk barefoot and their exposure to snake bites or leptospirosis is much greater than that of miners, while miners suffer more from respiratory illnesses than fishermen, and so on. Similarly, differences occur based on gender, age, region and other characteristics. Consequently, the priority given to different benefits will vary between groups.

To offer sustainable health microinsurance products, one needs to consider the four aspects summarized in Figure 6: product manufacturing, product sales, product servicing and the maintenance of long-term stability. This chapter analyses each of these components of health microinsurance.

¹ Some examples in this chapter come not from the case studies, but from the authors' own experiences, including references to Microcare and Panworld in Uganda, and BAIF and Uplift Health in India.

Figure 6



I Product manufacturing

All considerations start with product manufacturing. In its simplest form, this process involves decisions on the design and pricing of the benefits package. However, the parameters chosen affect the processes of sales and servicing, and the maintenance of stability.

Product manufacturing requires the definition of several elements: a specific target client group, the demand for insurance, the composition of the benefit package, pricing, the healthcare providers, as well as controls for moral hazard and adverse selection. The abstract dimension includes sustainable pricing that guarantees the stability of the scheme, as well as reliable claims management and the satisfaction of clients' demand for security (Albrecht, 1992). The actual design of the product lays the foundation for this abstract dimension.

1.1 Moral hazard, adverse selection and fraud

Moral hazard, adverse selection and fraud are commonly considered to be the main problems in health insurance, even though other factors like risk selection contribute strongly to market failures. Before delving into the other components of product design, it is helpful to define these problems, and explain why they pose a particular challenge in health insurance.

Moral hazard occurs when people with insurance use more services than they would if they did not have coverage only because they know that they are protected. Sometimes, insurance can actually provide a strong incentive to incur an insured loss. A client, for example, may have a longstanding health concern that was previously not considered sufficiently critical to treat (e.g. a hernia or uterine prolapse). However, after insurance coverage is obtained, the client might then decide to get the problem fixed under the insurance cover.

Adverse selection occurs when the risk profile of the group insured is worse than what would be expected in the general population. There are two main causes:

1. The insured group is not a true pre-existing group and sick persons have come together specifically to gain insurance benefits. An example of this occurred in a community-based health scheme in Uganda for farming cooperative members where some groups had higher-than-expected claims rates. Investigations revealed that these groups had no proof of pre-existing membership and had probably formed specifically to benefit from the health scheme.

2. Pre-existing groups with higher-than-expected numbers of sick members join an insurance programme when other healthier groups do not. This is a particular problem if group sizes are small. For example, Microcare (Uganda) rolled out group health insurance originally piloted with FINCA (which uses the classic village banking methodology where groups comprise 30 or more families) to another MFI, Pride Uganda, where group size can be five families. Thus small groups with several members with medical problems were quick to join the scheme, while groups made up of healthy individuals were less likely to enrol.

Either way, the cost of insuring these people will be higher than expected and often the claims are higher than the total premium collected, resulting in the scheme making a substantial loss.

Fraud: Health insurance is particularly prone to fraud throughout the world, whatever the clients' income levels. Even in highly sophisticated markets like the United States, health insurers dedicate substantial resources to fraud detection and control. The insurer runs the risk of fraud abuse from:

- the client, for example, obtaining treatment for persons not covered by the insurance scheme through impersonation,
- the health service provider, who might, for example, submit false claims or inflate genuine claims by claiming for more expensive drugs than those actually issued,
- the scheme administrators, including the insurer's own staff, who might, for example, process fake claims or process genuine claims twice, possibly operating in collusion with dishonest providers,

or any combination of the above.

Since schemes can easily collapse due to fraud, it is essential that fraud prevention mechanisms are in place before the scheme is launched. In the late 1990s, one of the largest general insurance companies in Uganda, Panworld, collapsed within a few months of introducing health insurance largely due to the massive level of fraud in the scheme.

Moral hazard, adverse selection and fraud exist in all types of insurance. They are particularly problematic in health insurance due to the subjective nature of the insured events. In life insurance, for example, the insured event is objectively verifiable – a person is either dead or alive. Or take the example of weather insurance: a building may be insured against damage caused by winds of 100 km/h or more – an objective, measurable phenomenon. While the risk of moral hazard exists, few people will choose death just to be able to claim under an insurance policy (though suicide is an exception, which is why it is excluded from most life insurance contracts). Likewise, while arson is a moral hazard for property insurance, it is relatively easy to investigate and detect.

However, sickness is more subjective, with occurrence often determined by healthcare providers motivated by a desire to encourage consumption of their services. While few people will elect to undergo heart surgery just because they are insured, the same cannot be said of simple outpatient care. In health insurance, moral hazard can be caused by both the provider and the insured, which is why moral hazard is a particularly difficult issue for health insurers.

Adverse selection is not exclusive to health insurance. Individuals who smoke or drink alcohol are more likely to suffer from diseases and face a lower life expectancy. A smoker or drinker who conceals this fact from an

insurance company when enrolling in life insurance is in effect a case of adverse selection, which can negatively affect the loss probability. However, as this example demonstrates, it is somewhat easier to hide personal information about one's health status than it is, say, about one's property or crop.

Therefore, adverse selection occurs most commonly in health insurance when people who know they have a higher than average risk of claiming buy the insurance (or low-risk people opt out). For example, a woman who has just learned she is pregnant will join a scheme with generous maternity benefits, or a person who knows he/she is HIV positive will join a scheme that covers antiretroviral drugs. The costs of such insureds drive the average premium upward with the consequence that people with below-average utilization may decide the insurance is too expensive and opt out. AssEF, a women's self-help association in Benin, included prenatal visits and birth in its benefit package. Although enrolment was open for the entire family, mainly women joined. The situation was aggravated by a massive dropout of members and pregnant women were thus over-represented among the remaining members. Thus, adverse selection might affect the scheme's risk-pooling and its economic viability.

By focusing on theoretical and technical aspects of health insurance, one runs the risk of ignoring the specific conditions of health financing in the developing world, where microinsurance could become an important component of social protection. What could be considered as demand-side, user-driven moral hazard is very likely to be nothing more than the expression of a real need for epidemiological and clinical treatment. In other words, it is not a question of over-utilization after joining a health scheme, but rather under-utilization prior to joining. And many microinsurers set out to tackle precisely this.

Nonetheless, in a given context, microinsurance has to define primary targets and to explore concrete measures for controlling undesired moral hazard and adverse selection. The approaches applicable in the specific context of health microinsurance will be treated in more detail later in this section; the chapter now proceeds to discuss the various elements of product manufacturing, starting with defining the target group.

1.2 Define the target group

The first step in product manufacturing is to define the target group. In general, health microinsurance only works with pre-existing groups; the premium required to cover individuals off the street would be prohibitively high due to the cost associated with adverse selection. Furthermore, as previously mentioned, products for different occupational groups will look different (at

least they should, as long as comprehensive coverage is not achieved and benefits have to be rationed). However, occupation is not the only factor to consider when defining groups; gender might be the most important characteristic, and regional differences can play a crucial role as well. Bienestar Magistral in El Salvador, for example, offers a scheme for public-sector teachers; the Union des Mutuelles de Santé de Guinée Forestière (UMSGF) defines its target group broadly as households in a certain area. For the latter, occupation does not play any role, but the area of operation restricts membership.

Defining the core target group should not necessarily exclude others. It may be in the insurer's (and the insured's) interest to include other household members as the burden of illness is often borne by the entire household. Several microinsurers have recognized this. In India, VimoSEWA's target group are self-employed women, and only members of this group can take out an insurance policy. However, self-employed women can decide to cover their spouses and children as well. Similarly, in Yeshasvini Trust (India), clients must be members of a cooperative society, but they can also cover their entire family. The insurance scheme could even require an entire household to join (or to offer a reduced fee as an incentive if this is done). At Uplift Health in India, for example, members are expected to enrol their entire household, and failure to do so results in a doubling of individual premiums.

Whatever the criteria used for group definition, it is important to select the target group in a way that is conducive to group cohesion. If there are no strong ties or there is generally a low degree of social capital among group members, they are more likely to display selfish behaviour, including higher degrees of moral hazard and adverse selection, as well as a lower level of renewals after a year with no claims.

1.3 Study the demand

Once the target group has been defined, its needs must be carefully understood. For this purpose, Karuna Trust in India worked with a research institute to conduct a baseline study of the target population. In a household survey, healthy behaviour, spending on health, knowledge about insurance and willingness to pay for insurance were examined. The results were taken into account when designing the benefit package. As the high cost of medicine proved to be one of the main burdens for households when illness occurred, a drug fund was initiated as part of the insurance scheme. As a response to the reported high indirect costs of illness, Karuna also decided to compensate loss of wages when insured clients are hospitalized. Other institutions use their field staff to conduct demand research. BRAC (Bangladesh), for

instance, consulted groups and individual members about their preferences; VimoSEWA's research department relies on the feedback from its field staff.

1.4 Define the benefit package

A benefit package can then be designed based on the insights gained from demand studies. Defining the benefits of the product and the premium required to obtain these benefits makes up the core of product manufacturing. Both aspects determine the market opportunities for the product and the balance between the needs and wishes of the target group.

In any insurance arrangement – and microinsurance is no exception – aggregating risks through pooling is key. However, not every risk can be pooled. The following preconditions need to be met in order for the risk to be insurable and transferable into an insurance solution (Churchill et al., 2003; Brown and Churchill, 1999; Vaté and Dror, 2002):

- **Randomness:** The occurrence of loss or damage must be unpredictable. Otherwise, systematic saving is a better alternative because risk pooling would not result in lower premiums.
- **Low probability of occurrence:** If the majority of members are likely to incur a loss or damage, premiums will be similar to the cost of individual provision.
- **Independence of risk:** Collectively insured risks of individuals have to be independent with regard to their occurrence in order not to threaten the long-term stability of the insurance.
- **Uncontrollability of loss or damage:** The policyholder should not be able to cause the occurrence of loss or damage.
- **Unequivocal:** The insurer must be able to verify the occurrence and the scope of loss.
- **Existence of insurable interest:** For an individual to be interested in an insurance solution, the loss must have adverse financial consequences. The potential losses should be high in relation to the cost of premium payments.

Insurable risks should have a low probability of occurrence, yet strong adverse consequences if the risk does occur. This is where risk-pooling mechanisms come into play. Since part of the individual risk is borne by the entire group of policyholders, the individual risk premiums can be relatively low in relation to the size of a potential loss. The more frequent the occurrence of loss, the more difficult it becomes to insure. The greater the chance of an event occurring, the closer premiums will be to the amount of a potential

loss, so that the event will ultimately no longer be insurable at a price that clients will find acceptable.

The classic case of an insurable event in the health sector is hospitalization, with a low probability of occurrence but high costs. VimoSEWA reimburses the cost of hospitalization up to a certain amount for its members. However, the preferences of a target group might go beyond these low-frequency events as households seek to cover frequent events as well. Simple outpatient medical treatment, with lower costs but higher probability, falls into the category of hardly insurable risks from the insurance provider's perspective, as the administrative costs of settling claims are often too high.

This highlights one major difference between the preferences of insurance providers and policyholders. Insurers like to cover rare, high-cost events, and dislike many small claims that drive up administration costs. In contrast, insureds are loss-averse, preferring products that reduce their losses, which do not necessarily result from low-probability, high-cost events, but rather from an accumulation of low-cost, high-probability events.

Besides the insurer-insured conflict, there is a further conflict of interests within the insurance scheme. If minor illnesses suitable for outpatient treatment were not covered by health insurance, the policyholder would have an incentive to delay treatment until the health condition is serious enough to warrant a claim. In the end, delayed treatments can become very expensive for the insurer. Incentives aside, many poor people find it difficult or impossible to pay for the treatment of what are initially minor diseases in periods of low income (e.g. agricultural workers whose income is seasonal). There is also the additional perverse incentive for a doctor to admit patients unnecessarily to benefit from the income available from the inpatient coverage.

The postponement of treatment may lead to severe deterioration and ultimately cause higher costs for the insurer. Therefore, it may be in the insurer's interest to encourage people to seek treatment early, while ensuring that they do not use the health services unnecessarily or excessively. Prevention and regular health check-ups fall into the same category. Although the benefit package of Yeshasvini Trust focuses on surgery and succeeds in offering rare but high-cost treatments like heart surgery for a reasonable premium, it also includes free outpatient consultations to encourage members to seek care at an early stage. How often a benefit like outpatient treatment – if granted without limitation – is used is determined only by the insured, and hence the “uncontrollability of the loss” criterion is not fulfilled. The same is true for health check-up camps, optional surgery or childbirth. They cannot really be risk-pooled, but many schemes nevertheless find it necessary to include these benefits.

When covering frequent but (relatively) low-cost events, schemes have to limit the scope of benefits or increase the fees accordingly. One UMSGF mutual offers outpatients services and drugs for a flat fee co-payment. The insurance product of Grameen Kalyan (Bangladesh) provides a range of services, but limits coverage to a certain percentage of the actual costs for benefits accessed at external healthcare providers. This restriction – either in the variety of benefits, the total amount covered or the co-payments patients need to bear – is a logical consequence of the limited premium that insurers can charge their clients.

A problematic issue is the treatment of chronic diseases and their long-term effects. These are often difficult to identify (and consequently prone to adverse selection), and therefore constitute a potential for conflict with the insured. The same is true for diseases like HIV/AIDS, where long-term treatment is necessary – and costly, generally exceeding the financial capacity of the individual. However, consequent and comprehensive treatment of HIV/AIDS-infected individuals can turn out to be highly cost-effective as proven in the case of Brazil (Holst, 2005b). As international drug prices for antiretroviral treatments are falling, cost-effectiveness might eventually become achievable even for microinsurance (Jamison et al., 2006). Inclusion and coverage will depend on the solidarity principle and the degree of social capital among the target group. Microinsurance schemes are therefore facing a challenge in obtaining sufficient resources in the short term to treat HIV/AIDS properly and prevent disease progression, and ultimately benefit from long-term reductions in claims costs for people living with HIV/AIDS.

The clients of Microcare defined their degree of solidarity with the chronically ill themselves. Instead of excluding the chronically ill, the clients decided not to include the medication for chronic diseases in the benefit package. Hence, Microcare does not cover insulin for diabetics, inhalers for asthmatics or anti-epileptic for epilepsy. This exclusion was originally suggested by low-income MFI clients during the pilot scheme design when they realized how much higher premiums would need to be to cover these costs. The clients decided that “these people are already paying for their long-term medications. Let them continue to do this, but do not prevent them from receiving the other benefits of the scheme”.

Alternatively, coverage for chronic diseases could depend on third-party financing. Karuna Trust circumvents some of these limitations by collaborating with public healthcare providers, which provide free treatment to people around the poverty line. Hence, the benefit package of Karuna Trust can focus on complementing this public infrastructure and tackling some of its shortcomings. In the event of hospitalization, Karuna’s clients are entitled to receive drugs not available at the public health providers and are compensat-

ed for wage loss while hospitalized; also, free ambulance transport is provided in cases of emergency. Thanks to a subsidy from UNDP, Karuna Trust is also introducing coverage for HIV/AIDS-related costs.

Lastly, the time (term) for which the benefit package is offered to individuals, households or groups has to be defined. The vast majority of microinsurers use a one-year term and renew the contract with the client annually. A shorter period usually does not make sense as it makes balancing the risk more difficult and people might join just for the time when they are ill or for a particularly susceptible period of the year, for example the rainy season when malaria is much more prevalent.

1.5 Define providers

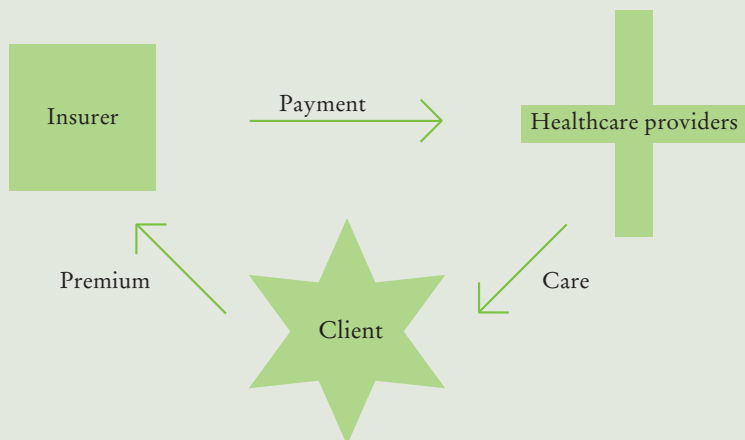
Besides defining the benefits, the modes of service delivery and technical procedures need to be established. While the former determines the relationship with healthcare providers, the technical procedures define how claims are filed and who may be involved in this process.

There are three main alternatives for determining the relationship with healthcare providers:

1. The insurers select specific healthcare providers that clients use and conclude a **formal agreement with the providers** (Figure 7). The insurer usually pays the provider directly for services rendered to the client. This solution is based on the benefit-in-kind principle, whereby the policyholder receives the service rather than money to purchase the service. Yeshasvini Trust established a network of 150 mainly private hospitals that deliver services to clients according to a predefined rate. Patients receive cashless benefits after approval from the insurance administrator.

Figure 7

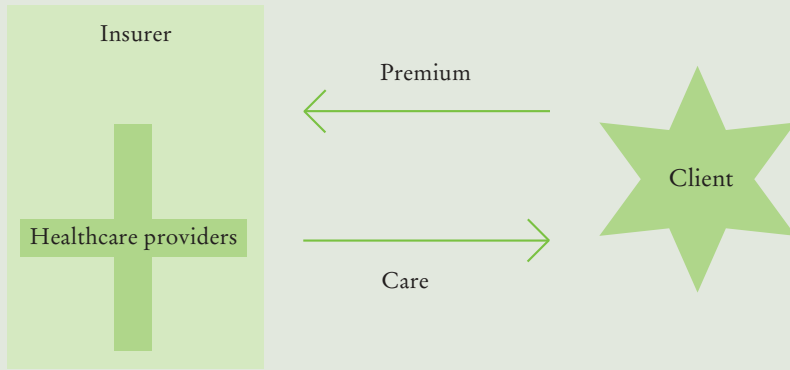
Claims model 1: Insurer pays healthcare provider (third-party payment)



2. Another way of delivering benefits in kind is to **combine the healthcare and insurance providers** (*Figure 8*). In this case, the insurer hires its own healthcare staff either for inpatient treatment or as mobile service providers (or alternatively a healthcare provider could launch an insurance scheme). If the insurer has only a few permanent healthcare professionals in a specific region, the employed service provider does not profit from economies of scale – this is a challenge currently facing ServiPerú. It means that certain services will not be offered at all or cannot be offered in a cost-effective manner. However, in regions with a poor healthcare infrastructure, this may be the only way to offer health microinsurance (*see Box 17*).

Figure 8

Claims model 2: Integrated healthcare and insurance provider (internal financial transaction)



Box 17

BRAC's three-tier approach to providing health services

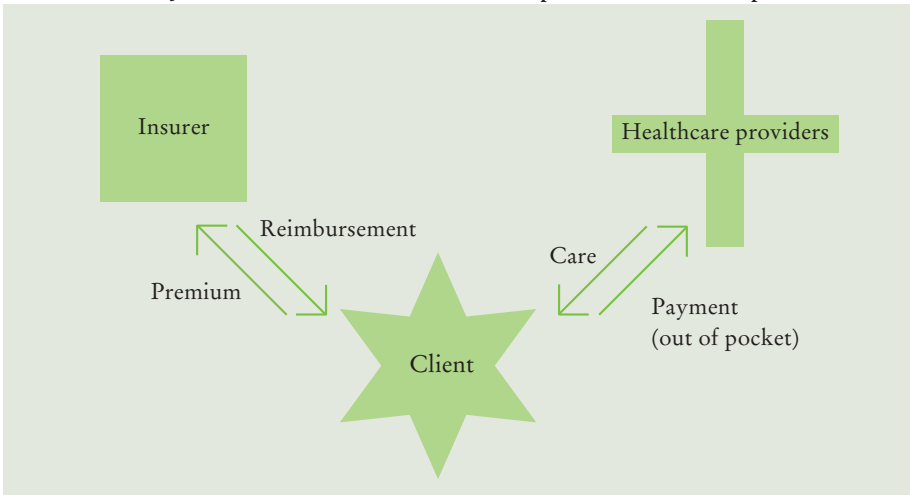
The BRAC Health Programme in Bangladesh is aimed principally at the community, with a particular focus on women and children, though men are not specifically excluded. The scheme is implemented through three tiers. The first tier is a cadre of part-time community health workers, called Shashtho Shebikas (SS), who are mostly female front-line workers of BRAC's Health Programme. They go door-to-door to educate community members on critical health matters, provide treatment for basic ailments and essential health commodities, and help to create "health-empowered" communities. The second tier is a cadre of health paramedics, all women, called Shashtho Kormis (SK). These paramedics oversee the work of the SS, provide pregnancy-related care, and hold health education forums where the community's health concerns are addressed. The third tier is a network of health clinics, called BRAC Shushasthos, that provide technical backup to the SS and SK, who refer patients that they cannot treat to these centres. The

Shushasthos provide treatment and diagnostic services, have comprehensive laboratories, outpatient facilities, and inpatient services, all supported by qualified nurses and physicians.

Adapted from Ahmed et al., 2005.

3. The third option is to reimburse clients for their healthcare expenses (*Figure 9*). Here, clients can consult a trusted physician or hospital, pay for the service and then submit the bill to the insurer for reimbursement. This solution offers the client the greatest possible choice (although many schemes work together with health providers who have to meet certain requirements). However, it also places a heavy financial burden on the clients while they wait for reimbursement. Lack of money is a major difficulty for many low-income people and might prevent them from seeking healthcare, especially the vulnerable groups (the poorest, women, children). VimoSEWA uses this approach, but recognizes that it is not ideal for its members. Consequently, it has launched a pilot project to address this problem: clients can contact a field worker when approaching a hospital, and receive up to 80 per cent of the estimated costs in advance.

Figure 9 Claims model 3: Insurer reimburses clients' out-of-pocket healthcare expenses



There is an increased risk of fraud by clients in the third option since they could forge or modify receipts to obtain extra money. It is also more difficult for the insurer to go back to the health service provider to verify the claim if there are a large number of service providers with no contractual relationship with the insurer. Claim rejection will also compromise the relationship with the client and undermine the insurer's reputation if it is the client who is penalized by the rejection rather than the service provider.

For each of these alternatives, the insurer has to define the claim processing and payment procedure for the service provider. For instance, billing can be per client or per service rendered. There is a wide range of settlement procedures, each entailing different incentives for the provider to offer more or fewer services to the insured.

Regardless of how the provision of healthcare services is organized, it is essential to have mechanisms to verify the services rendered. This task is accomplished in the phase of product servicing. Nonetheless, the questions as to how to control the quality of healthcare services, how to ensure that claims are warranted and how to prevent fraudulent claims must already have been dealt with in the product manufacturing process.

1.6 Mechanisms to avoid moral hazard

As highlighted at the beginning of this section, health insurance carries a high post-contractual risk of fraud and moral hazard, i.e., behaviour that violates the spirit of the contract. Due to asymmetric information, it is impossible for the insurer to check whether the insured has actually incurred a loss or whether he has negligently permitted the loss to occur. Likewise, it is difficult for the insurer to prove excessive use of health services. A traditional mechanism to tackle this problem is a **co-payment**, which is used by UMSGF, BRAC, Grameen Kalyan and others. Interestingly, Grameen Kalyan increased its initially modest co-payments, not to reduce over-utilization, but to signal its quality of care; clients perceived low-cost treatment as poor-quality care.

However, cost-sharing has a number of theoretical weaknesses and empirical disadvantages (Arhin-Tenkorang, 2000). First, over-use does not appear to be a major problem in developing countries, where there is a lack of adequate healthcare and therefore access is usually restricted indirectly by related opportunity costs. Second, cost-sharing counteracts prepayment for healthcare and is thus contradictory to health (micro)insurance. User charges have a negative impact on the most vulnerable groups and prevent the neediest from seeking care, thereby rationing care instead of rationalizing it. The mutuels in the Union Technique de la Mutualité (UTM) in Mali were founded for the sole purpose of helping their members pay the co-payment for health facilities.

The nature of the benefit can play a role in reducing moral hazard. For example, Yeshasvini Trust operates under the assumption that nobody voluntarily undergoes unnecessary surgery. By contrast, Microcare's co-payments have always been in place for community-level schemes, but they are relatively low (between US\$0.30 and US\$0.80 for Mission Hospital services). These payments are not regarded as a substantial means of cost recovery or a significant contri-

bution to cost-sharing, but are intended to prevent frivolous over-utilization of services by clients living close to the hospital or clinic.

Microcare's co-payments are also used to include different levels of service providers in the same basic insurance plan by assigning a higher co-payment (US\$1 to US\$3) for the more up-market urban private clinics. Some micro-finance clients have adopted the attitude that their time is valuable, preferring to pay extra for a private clinic where they are treated quickly, so that they can return more quickly to making money again in their small businesses.

1.7

Pricing

To design a product that responds to client preferences, information about their willingness to pay and preferred modes of payment has to be obtained (and should be included in the demand study, as described above). To calculate the optimal premium using actuarial methods, the insurer must first define the insurable unit. For instance, UMSGF defines families as the insurable unit, which reduces the risk of adverse selection by spreading the risk within the unit.

As described in Chapter 3.5, the total costs of insurance benefits can be estimated using estimates of expected healthcare utilization and costs. By adding expected administrative costs, contingency reserves – and in case of a for-profit insurer, a profit margin – the insurer can calculate the expected funding need. In principle, the larger the (expected) insurance pool, the lower the (fixed) administrative cost per policy. By operating through the cooperative sector in Karnataka (which has several million members), Yeshasvini Trust achieved a big target population and thus reduced the (fixed) administrative costs per insured considerably.

To avoid undermining policyholders' trust, frequent or substantial changes in premium should be avoided. When Yeshasvini realized that it needed to double the premium, a third of its clients did not renew their policies. Similarly, Karuna Trust had to engage in a massive trust-building exercise when its insurance programme stopped being subsidized. Half the clients dropped out initially, and only after an intense effort by Karuna's field staff was it possible to increase numbers.

While the latter was a strategic donor mistake, the first example, Yeshasvini, could have been prevented with reliable data. Reliable data needs to be obtained on the costs of services and the frequency of utilization. Yeshasvini fixed the parameter cost by defining a flat rate payable to all network hospitals; however, frequency of utilization turned out to be much higher than expected.

Generally speaking, in contrast to most consumer goods for which the production costs are known at the time of distribution, the costs of the insurance product lie in the future. Human error aside, the key problem is the stochastic (random) character of the insured loss. Even with a sound estimation based on reliable data, losses caused by unfavourable stochastic events may endanger small insurers. Possible ways to prevent this from happening are discussed in the section on maintenance of stability.

The frequency of premium collection also affects the total amount of premiums to be paid. If annual premiums are paid in advance, they can be invested in financial markets to generate surplus funds (unless they are used for claim settlements). Thus, where there is access to financial markets, the effects of inflation may be alleviated.

While annual premiums lower transaction costs, and theoretically increase investment income, it may be difficult for the target group to come up with the entire amount. In fact, this is another potential area where the interests of the insurer and the insured are different, as the poor often prefer to pay US\$0.10 per week rather than an annual premium of US\$5.20. The relatively small size of the premiums and the clients' preference for small frequent payments pose a challenge to insurers.²

As discussed in Chapter 3.3, microinsurers have found innovative ways to resolve the premium payment issue. VimoSEWA uses a fixed deposit method, whereby interest from a savings account pays a member's annual premium. Karuna Trust installed a health emergency fund to make loans available to pay for uninsured risks, and also to pay premiums. Microcare developed a loan product with FINCA Uganda whereby a premium for a 12-month coverage period was paid back over a four-month loan period to FINCA. This proved very popular with clients, the only difficulty being the interest rate charged by the MFI. Where possible, it is preferable for microinsurers to assist clients to save up to pay an annual premium rather than borrowing to pay it.

The tasks that have to be accomplished during product manufacturing are summarized in Table 7.

² Interestingly, BRAC's experience on this is different: when offered the option to pay their premium weekly, clients explained that this would clash with their weekly savings and that fewer instalments are preferred.

Table 7

Overview of product manufacturing tasks and features

<i>Tasks</i>	<i>Features</i>
Determination of coverage adapted to the target group	Demand analysis (direct dimension)
Actuarial premium calculation	Feasibility study (abstract dimension)
	Methods of premium collection and investment of surpluses to reduce premiums
Definition of insurance procedures/organization of the insurance product	Definition according to actuarial requirements
	Definition according to client requirements

2 Product sales

The sales process can be subdivided into two categories: a) information provision and b) underwriting.

2.1 Provision of information

Each sales process starts with the provision of information. The unique feature of microinsurance sales is the extensive information needs of the target group, which often lacks experience with insurance. The sales agent must explain the prospective nature of premium payments and the retrospective nature of claims, and why the premium cannot be repaid (at least in full) if no illness occurs. The experience of health microinsurance providers shows that it is difficult to explain the idea of advance payments for services that may perhaps never be used. Schemes therefore use various contacts with clients, including health workers. For example, AssEF, BRAC and Grameen Kalyan use their savings and credit groups to promote health microinsurance.

If potential clients are interested in insurance, the salesperson provides detailed information on eligible and excluded services and the procedure for filing claims. Future clients should be familiar with the required documents and the deadlines that need to be met for successful claims settlement. Unclear procedures or benefits may soon cause dissatisfaction among clients. Yeshasvini Trust, for instance, has a list of 1,600 types of surgery that can be obtained at certain hospitals. This makes it difficult to communicate the

insurance coverage as much of the information is technical, which can result in confusion and dissatisfaction.

It is not easy to communicate technical information to an uneducated clientele. For the sake of credibility, the information should be relayed by someone who has the potential clients' trust. Trust is the very foundation of any insurance market. From the clients' point of view, there is a principal-agent problem. Due to asymmetric information, they usually cannot tell how the product and pricing were designed (especially the commissions and profit margins included in the premium), or if an insurance provider will act against the interest of the insured or comply with agreements.

For clients to accept such a deal, the insurer's obligations should be enforceable through the legal system. For microinsurance, however, the costs of legal action will quickly exceed the (financial) value of the claim as well as the potential policyholder's financial capability. Formal systems of legal action often do not function well in developing countries. In the absence of enforceable contracts, if potential clients have doubts about whether the insurer will meet its obligations, they are unlikely to buy the cover. Only trust will make risky advance premium payments possible. A potential client must be confident that the insurer will meet its obligations in two ways:

1. Trust in the willingness to meet obligations

A potential client must expect the provider to settle a justified claim. Clients must either assume that it is in the interest of the insurer (intrinsic motivation) to fulfil its part of the agreement (trust in a narrow sense), or have confidence in their own ability to influence or put pressure on an institution (trust in a broad sense).

2. Trust in the ability to meet obligations (confidence)

The client must believe that there will be enough money in the insurer's coffers to pay claims over the long term. The size of the insurance provider and the subjective perception by potential clients of the reliability of the organization (abstract dimension) are the two determinants of confidence for long-term relationships.

Knowledge of the target group improves the quality and thus the efficiency of the relayed information – not only in terms of content, but also of style and the communication channels used. The professional quality of the information and the degree of trust among the target group are the first challenges to be overcome in the sales process. In Cambodia, GRET conducts a three-step sales process for its health insurance scheme. In two consecutive weeks, GRET employees inform potential clients and answer questions. The insur-

ance agent, who handles the actual underwriting process, does not arrive until the third week (Brown and Churchill, 2000).

SEWA also capitalizes on its long relationship with the target group, its knowledge of their needs and preferences, and its experience in communicating with the clients to gain their trust. Similarly, Karuna Trust, BRAC and Grameen worked on health and community development for years before going into insurance. In fact, many health microinsurance schemes started with other activities and only later introduced insurance. The trend to evolve from basic microfinance operations into health insurance is an area that would warrant closer examination, as the regulatory and operational environments for microfinance and health microinsurance require different structures and skill sets.

The lack of a relationship of trust and direct contact (both physical and psychological) with potential clients usually prevents insurance companies from entering the low-income market directly. Where an insurance company is involved in health microinsurance, a local institution (the agent) usually distributes the product on its behalf. However, agents need to be paid, which makes the product more expensive than distribution models without agents. This is not a direct problem for the insurer, as it is passed on to its clients, but it can make the cost prohibitive for some low-income households. This conflict of interest between the insurer and the insured in the sales process is discussed in Chapter 4.4.

Regardless of the distribution channel, explaining insurance remains a challenging task. Most health microinsurers acknowledge that they have to find better ways of marketing health insurance benefits. As described in Chapter 3.2, street theatre, posters and cartoons are all important marketing tools for microinsurers. Many institutions, like VimoSEWA, make use of existing self-help groups to disseminate information about the beneficial attributes of health insurance for members. However, most schemes indicate that it is not enough to provide the information once; it has to be a continuing process to achieve a true understanding of insurance, and only then will positive operational outcomes such as a reasonable renewal rate ensue. Continuous provision of information is part of customer relations and is discussed further in the section on product servicing.

2.2

Underwriting

After providing information, the next step is to issue policies to clients who opt to be insured. In this underwriting process, the necessary data and information on the future policyholder is gathered. Depending on the design of the insurance product, this may include not only personal data, but also

information on the state of health, e.g. chronic diseases, and pre-existing conditions that may be excluded from coverage.

Exclusions must be defined for each insurable unit, for instance a family. Thorough information on states of health and family sizes has a significant impact on the quality of measures to reduce adverse selection. A preliminary health examination may be an integral part of the underwriting process, although many microinsurance schemes use simpler methods like a **declaration of good health**. In this declaration, the scheme learns about a person's health status based on information supplied by the insureds themselves. Rather than bringing to light any pre-existing illness, it is intended to make people aware of certain exclusions and provides an easy mechanism to assess them. It essentially shifts the underwriting from the screening to the claims process (*see Chapter 3.4*).

However, excluding people because of pre-existing diseases often contradicts the intention of socially-driven insurance providers. Thus, BRAC, Grameen Kalyan, the Society for Social Services (Bangladesh) as well as the Seguro Básico de Salud (Bolivia) and the Seguro Materno Infantil (Peru) decided to provide health insurance to anyone wishing to enrol. To make such unrestricted access feasible, additional mechanisms need to be put in place to stabilize the insurance scheme. Having wide group coverage or making use of the solidarity and social capital of communities to reduce moral hazard are possible options. Another way of reducing adverse selection is to introduce **waiting periods** for certain benefits. BAIF, near Pune in India, does not grant benefits for childbirth in the first nine months of membership. Another possibility is a reduction of benefits for new members (*see Chapter 3.1*).

For small risk pools in particular, the inadvertent acceptance of risks that would not normally be borne by commercial insurers can change the risk structure and jeopardize the viability of the scheme. The completeness of information determines the stability of the system. However, more effort put into information retrieval means higher costs for policyholders to bear.

One unique advantage of microinsurance is the possible involvement of the community in the sales process, which could lower information collection costs. In closely-knit communities, members know a great deal about each other and, given the right incentive structure, can leverage this social capital to reduce both moral hazard and adverse selection. For example, members of Uplift Health need to democratically decide whether they want others to join their risk pool. As their pool is kept small (although linked to larger ones), they will certainly think twice before accepting high-risk members. Social capital is used in Karuna Trust as well – though not for screening

adverse selection or moral hazard. At Karuna, only individuals below or at least around the poverty line are eligible to join the scheme; the self-help group members discuss whether applicants are poor enough to join.

Once an insurance policy is concluded, the first premium must be collected. When cashless collection methods are not possible, the premium needs to be collected directly from the member. Fraud is a significant concern when many field workers collect lots of small payments. To reduce the risk of fraud, Karuna Trust's social workers issue numbered receipts to control the number of policies sold.

When a premium is paid, the insurer must issue proof of coverage to the policyholder. For example, Yeshasvini Trust provides a photo identification card for its members. However, issuing these cards takes time, and the photograph adds additional costs. Issuing ID cards to Yeshasvini's 1.45 million clients involves significant administration costs and logistical challenges. It took up to three months to supply each member with the right ID card and enter each member's information in a database. While the cards were being processed, patients used letters from their cooperatives and their premium receipts to prove their eligibility. To reduce renewal costs, Yeshasvini has now decided to stop producing a new card each year and instead issue cards that accept a renewal seal. By selling advertisements on the back of the card, Yeshasvini hopes to raise additional income to help cover the costs.

Karuna Trust intends to shift to a photo ID-card as well, but currently accepts the premium payment receipt as proof of membership. As clients may add names to the receipts, staff need to compare the client's receipt with the copy kept on file. BRAC's Health Insurance Card contains a photograph of the head of the family and a list of the household members insured, and provides their age, blood type and relationship to the head of household.

Table 8 provides an overview of the tasks to be accomplished in the sales process.

Table 8

Overview of product sales tasks and features

<i>Tasks</i>	<i>Features</i>
Information	Provision of factually well-founded information
	Creation of trust
Underwriting	Information retrieval for the insurance
	Issuing of documents to the policyholder

3 Product servicing

Product servicing includes claims processing, maintenance of long-term client relations and relationship management with healthcare providers.

3.1 Claims processing

The documents required for filing a claim need to be checked for completeness and eligibility. To avoid moral hazard and fraud, all claims must be thoroughly scrutinized. This might require information from the policyholder's social environment, as well as verification by a physician. Different schemes use different approaches, for example:

- Insured patients at BRAC and Grameen Kalyan normally use the **health providers employed by the schemes**. Only 1 per cent of the patients are referred to external healthcare facilities for more serious illnesses and surgery. At Grameen Kalyan, the patients referred to external facilities submit their claim documents to a local branch of Grameen Bank; the branch manager, the local health assistant and the insurance's centre director jointly decide upon the reimbursement of the claim.
- At UMSGF, patients must **request authorization** before seeking treatment. Armed with the authorization and their membership card, they approach the insurer's representative at the hospital. A co-payment for the consultation is required, but all subsequent inpatient treatment is provided on a cashless basis. When discharged, the patient receives a voucher indicating the treatment performed and the period of hospitalization. The patient can use this voucher to **claim for the transportation costs** to the hospital. The hospital receives a direct payment from the insurer for the treatment after submitting a monthly statement. This statement is verified by comparing it with the vouchers collected from the insured.
- A **cashless mechanism** is used by Yeshasvini Trust as well as by the government schemes in Bolivia (SBS/SUMI), Peru (SMI/SIS) and Paraguay (SI). In Yeshasvini, insured patients approach one of the 150 network hospitals with the ID card and a letter proving their membership in a cooperative society for a free consultancy. If surgery covered under the scheme is required, the hospital submits a pre-authorization request to the scheme's **third-party administration** (TPA). Authorizing non-emergency surgery can take up to four days. Once authorization is given, all costs relating to the surgery are covered by the insurer at a predefined rate. The scheme reimburses the healthcare provider directly.

- Microcare issues **smart cards** carrying the photographs of the client and covered dependants. On presentation of this card at a Microcare check-in desk at a participating hospital or clinic, the identity and coverage entitlements of the client are verified using the networked **computerized database** developed for the insurer. The claims are entered into the system and processed in real time, permitting rapid payment for services rendered.
- Social workers are placed at the three **designated public facilities** with which Karuna Trust collaborates and ensure **immediate payment** when the patient is discharged from hospital.

3.2 Managing the relationship with healthcare providers

Having an insurer's own staff at a healthcare facility has a value beyond checking a patient's insurance status. These staff – like Karuna's social workers, Microcare's check-in nurses or Bienestar Magisterial administrators – offer guidance and look after patients' interests, ensuring, for example, that providers treat them in a friendly manner and offer quality care. A similar mechanism is applied by Uplift Health; patients who need treatment can call the scheme's doctor, who accompanies them to a hospital and ensures proper treatment.

This arrangement also helps avoid provider-driven moral hazard. Generally, neither the insurer nor the patient can assess whether the treatment was necessary and carried out in the most economic way. The insurer would have to bear high information costs to find out whether the treatment was necessary. As laypersons in medical matters, patients take health services on trust. They cannot verify whether improvements in their health are a direct consequence of medical treatment.

Yeshasvini tries to verify the necessity of expensive treatments by having a local representative of the scheme visit the health facilities concerned. This mechanism is also intended to prevent fraud. These district coordinators are supported by a doctor working in the scheme's head office. However, most healthcare providers are more knowledgeable about medical issues than microinsurers, and thus could easily mislead them.

3.3 Long-term relations with clients

The maintenance of long-term client relations includes the continuous provision of information, timely response to the changing demands of the clients and solving problems with the product or procedures. A positive experience with an insurance product will build trust among the members and may induce them to purchase additional benefits for a higher premium. The per-

manent information flow helps the scheme maintain client satisfaction and could help attract new clients.

An important element of client relations is the renewal of contracts for consecutive years. The premiums for most clients cannot easily be collected by automatic direct debit from a current account. Whenever premiums are collected on a recurring basis, transaction costs are high unless the collection can “piggyback” on existing mechanisms (*see Chapter 3.3*).

Clients who have not filed any claims in the past year present a real challenge because they need to be convinced that membership still makes sense. The renewal rates in many schemes are low; BRAC managed to increase the renewal rate from 15 per cent in the first year of operation to 50 per cent in the third year. Grameen Kalyan is also stagnating with a renewal rate of 50 per cent. Considering that it can be much more expensive to acquire a new customer than to retain an existing client, the low retention rates for health microinsurance pose a serious problem. Nevertheless, some schemes fare quite well; at UMSGF, 80 per cent of members renew their coverage.

Another reason to strive for frictionless renewal is because late renewals may count as new contracts. This implies that certain conditions imposed on new members, such as waiting periods or exclusions for certain treatments, will need to be reapplied. In VimoSEWA’s insurance product for instance, pre-existing conditions are not covered for six months.

If clients are well integrated into the system, they will identify with the microinsurer and be more likely to behave responsibly. This is a particular advantage of community-based schemes (*see Chapter 4.3*). For example, in Uplift Health’s mutual insurance scheme, the members monitor each other and press for healthy behaviour. If members jeopardize their health unnecessarily, the other members might refuse to renew the person’s contract or accord only a partial reimbursement of costs. In other institutional models, similar results can be achieved through claims committees consisting of policyholders and knowledgeable employees of the insurer. In general, when policyholders assume responsibility for the scheme, social capital is likely to have a positive impact on moral hazard.

To this end, it is beneficial to have preventive health activities integrated into the microinsurance scheme, to maintain an ongoing communication with the clients, as well as providing them with a tangible benefit even if they have not fallen sick and utilized the curative services. For example, Microcare offers HIV prevention activities and a malaria prevention programme that distributes insecticide-treated bed nets (*see Chapter 3.9*).

The organization and implementation of health education and prevention programmes may be suitable not only to show a positive presence among the target group, but also to lower the financial burden of severe illnesses that

cause high insurance costs. BRAC and Grameen Kalyan both organize annual health check-up camps for their members. BRAC also launched a HIV/AIDS information campaign among its members and participates – like Grameen Kalyan – in the government’s immunization campaign.

Some product servicing tasks overlap. For instance, verifying a client’s claim also involves verifying the healthcare provider’s services – both provider- and patient-driven moral hazard can be minimized by a single procedure. Karuna Trust’s hospital-based social workers can check with patient and provider, and thus monitor the behaviour of both. Yeshasvini Trust and Bienestar Magisterial require a pre-authorization before surgery, and may include a verification visit in the case of a high-cost surgery. A close relationship with healthcare providers generates knowledge of their strengths, weaknesses, and prices, which improves the quality of the guidance and consulting on health services offered to the client.

Product servicing tasks and features are summarized in Table 9.

Table 9

Overview of product servicing tasks and features	
Tasks	Features
On-the-spot client support	Client assistance (claims management)
Relationship with the healthcare service provider	Verification of claims and reduction of moral hazard
	Quality control
Long-term client relations	Guidance and consulting on health issues
	Information retrieval and processing
	Maintenance of client relations
	Renewal management

4 Maintenance of long-term stability

A key task for any insurance scheme is to ensure long-term stability. The stability of an insurer guarantees that its clients’ claims will be settled. It represents the abstract dimension of the insurance product.

Maintenance of long-term stability involves the **financial management** of the insurance provider, permanent risk monitoring, and particularly the management of the overall actuarial risk (*see Chapter 3.6*). An insurer’s existence is threatened when aggregate losses exceed the sum of premium payments and capital reserves (actuarial risk). Partial risks occurring in subsets of

the insurance pool do not necessarily threaten the insurer's existence as long as cross-subsidization and reserves are sufficient. It therefore makes sense to spread risks broadly across different subsets to reduce the danger of covariant losses, i.e. losses that influence each other, as in the case of epidemics. BRAC, for example, not only serves the poor, but includes more affluent clients as well. However, many microinsurers are too small to spread and pool their risks effectively.

The clients of health microinsurance schemes overlook these technical considerations relating to long-term stability. From their perspective, investment in future years seems less relevant than paying back "unused" premiums for the current year.

Actuarial risk has two main components. The first is "parameter risk" arising from incomplete information on the actual probability of loss. The second component is "process risk" arising from the random nature of benefit costs, which would still remain due to the randomness of events even if the true probability of occurrence were known (Albrecht, 1992; Dror, 2001). Parameter risk can be subdivided into statistical inference (predictions derived from data on previous events are prone to error) and forecast risk arising from the uncertainty about the validity of past statistics for the future (e.g. possible changes in diseases). Forecast risk is the most serious component (Albrecht, 1992).

As a consequence, the insurer must rely on sound professional knowledge as well as on reliable data to guarantee long-term stability. The collection of **reliable data** has to continue beyond the product manufacturing process for monitoring and modification purposes. The scarcity of data, however, is a major problem for microinsurers. Therefore, there is a need for timely and efficient transfer of data on insured risks, incidence of events and the resulting costs among the insured population. Ultimately, this could be done using software that would simplify and automate accounting and reporting operations, starting with the registration of newly enrolled members, up to and including reinsurance calculations. Management software, like that used by Microcare, would help capture data and make it available for easy analysis; it would help link sales and servicing with maintenance of long-term stability and, ultimately, back to (new) product design.

The **claims statistics for subsets** need to be checked continually. If errors have been made in the premium calculation, these must be corrected, possibly through iterative adjustments. Many microinsurance schemes have had to **adjust the premium**. Grameen Kalyan did not use actuarial calculations to set the premium; it has been set through trial and error and continuous consultations with its members. Like Grameen Kalyan, ServiPerú generally revises the premium every year taking into consideration the costs of the var-

ious benefits paid. VimoSEWA aimed to close the viability gap by increasing the premium from Rs. 12 (US\$0.24) in 2002 to Rs. 39 (US\$0.78) in 2005 for the health insurance component³ and legitimized the increase through an improved benefit package. An improvement in the benefit package was not offered when Yeshasvini Trust doubled its premiums in 2005 for the sake of stability – and as a consequence, the number of clients declined by a third. Downward adjustments of the premium are also possible, as Karuna Trust showed when it had a loss ratio of less than 100 per cent. UMSGF had a similar experience, but decided to stick to the existing premium and set aside any surplus as reserves, which is perhaps a wiser decision for attaining long-term stability.

Another approach to achieving stability is to generate income from other sources. If the policyholders' premiums are well invested, the accumulated reserves can be used to lower the premiums or to cover unexpected losses. However, in most schemes, the premium income barely covers the claims due to clients' limited ability to pay. Therefore, it is generally not possible to invest premiums to generate additional revenues, although there are a few exceptions.⁴ Some organizations, including Grameen Kalyan and VimoSEWA, have generated additional income by investing subsidies or endowment funds (*see Chapter 6.1*).

As shown in Table 10, several health microinsurers appear viable when claims are compared with premium. However, when all expenses are taken into account, many clearly still need subsidies. BRAC and Grameen use their own healthcare staff, the costs of which are only partly covered by the premium collected; hence, they have high administrative costs compared to premium collected. It is interesting to note that the renewal rate is highest in mutual schemes, but the number of schemes compared is too small for firm conclusions to be drawn.

³ VimoSEWA's insurance product covers various risks. The relationship between the premium and specific benefits is not shared with the policyholders; they pay a set amount for the entire package, which includes life and asset protection as well as health.

⁴ UMSGF earned investment income of 0.1 per cent of net income in 2000, which increased to 2.8 per cent in 2004. Yeshasvini Trust built reserves out of excess contributions and earned investment income of Rs. 3,700,000, or 2.6 per cent of the scheme's total income. However, Yeshasvini also received public subsidies in the same year.

Table 10

Some key ratios of health microinsurers

	<i>Claims/ Total premium (%)</i>	<i>Expense ratio (%) (Total expenses/ Total income)</i>	<i>Adminis- trative costs/ Premium (%)</i>	<i>Reinsur- ance premium/ Premium income (%)</i>	<i>Renewal rate (%)</i>
Karuna Trust (2004)	115	n.a.	18	–	n.a.
Yeshasvini Trust (2004)	140	n.a.	10	n.a.	69
BRAC (2004)	56	452	397	–	51
Grameen Kalyan (2004)	6.9	61	3 918	–	54
VimoSEWA (2004)	74	133	137	n.a.	51
AssEF (2004)	75	124 ¹	55	–	n.a.
UMSGF (2004)	42	27.9	21	2	81
UTM (2003)	40	n.a.	15	n.a.	100
ServiPerú (2003)	31.5	99 ²	19.5	15	71

n.a.: information not available; – not applicable

¹ This figure is without subsidies; with subsidies, the expense ratio was 83 per cent.

² This figure reflects the average last four years.

An element of risk always remains. Bearing this risk is the task of the insurer. An alternative to bearing risk is **reinsurance**, through which part of the risk is outsourced to an external provider. The smaller the risk pool of a health microinsurance scheme, the higher the need for reinsurance because unexpected costs can hardly be covered by reserves and because claims variability is much greater in smaller risk pools. However, while formal insurers have access to reinsurers, informal health microinsurers currently lack this access.

Whether or not an insurer should seek reinsurance depends on the magnitude of the accepted risks in relation to the insurer's financial capability and the probability of loss. If the magnitude of potential loss is high, the insurer should seek reinsurance, even if the probability of occurrence is low. Losses of low magnitude, which from the viewpoint of formal insurance companies are typical of health microinsurance pools, should be borne by the insurance company itself. However, most small microinsurers cannot accumulate sufficient reserves to be prepared for a series of bad years. Furthermore, reinsurance may offer a cheaper way to ensure sustainability than reserves (*see Chapter 5.4*).

Who manages and carries the risk is a critical issue for all insurance schemes. While the participatory nature of community-based schemes appears attractive, they may not have sufficient expertise to manage risk and have limited options for sharing the risk (e.g. reinsurance). Linked to the carriage of risk is the management of reserves. If a scheme lacks adequate

reserves, it may not be able to pay for services rendered if higher than expected claims occur. This can quickly erode the confidence of the health service providers, which will in turn affect the quality of service delivery and ultimately impact the clients.

Table 11 summarizes the tasks outlined above.

Table 11

Overview of the tasks to be undertaken to maintain long-term stability

<i>Tasks</i>	<i>Features</i>
Financial management	Use of financial markets
	Application of skills and knowledge
Monitoring the stability of an insurance pool	Monitoring of losses (in retrospect)
	Monitoring the risk structure (in anticipation)
Management of total actuarial risk	Broad spreading of risk
	Reinsurance if necessary

5

Conclusion

In many aspects, problems associated with health insurance are true of other microinsurance products as well. Education and information about insurance are a necessary precondition for satisfied customers. Furthermore, the benefits must correspond to the needs and expectations of the clients. However, while for other microinsurance product lines a consensus seems to exist that high-cost, low-frequency events are especially worth covering, this does not necessarily hold true for health. The poor are very much aware of the burden of low-cost, high-frequency events, but these are difficult for a health insurer to cover. The claim process produces high costs as it is difficult and expensive to obtain the information needed for claims' verification. For a viable health insurance scheme, it is therefore recommended that the policyholders and the community be involved in the business process, thus mobilizing their social capital. The greater the degree of convergence of the interests of insured and insurer, the more viable the arrangement will be.

2.2

Long-term savings and insurance

James Roth, Denis Garand and Stuart Rutherford

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As described in Chapter 1.2, one way low-income households manage risk is through savings. Unfortunately, there are a number of limitations to this strategy, including: 1) the challenges that the poor face in amassing assets and 2) the inability of their small nest eggs to cope with major losses. A possible solution to the first problem is a contractual savings account, also known as a commitment or recurrent savings plan, which helps create savings discipline and build up assets over time. As for the second problem, the savings facility could be linked with insurance to address major losses.

This chapter explores the possibilities for extending long-term contractual savings and insurance to the poor. The first section considers the reasons why more low-income households do not have better access to savings, and how insurers might be a possible source for such services. Next, the chapter reviews the current products of this type that are available to the low-income market. The final section looks at what microinsurers can do to bridge the gap or at least contribute to bridging the gap between the insufficient supply of long-term contractual savings and the demand for such services by the poor. It also examines the benefits and risks of such policies and suggests ways in which these risks can be managed.

1 Providing savings to the poor

Despite evidence that there is a demand for formal savings services for low-income households,¹ the actual supply is quite low. A glance through the MIX data (2004) on the performance of microfinance institutions indicated that of 302 MFIs for whom data was available, the institutions averaged 62,246 active borrowers, but only 33,657 voluntary savers.² Of course, many

¹ For example, see MicroSave Briefing Note # 6: The Relative Risks to the Savings of Poor People: www.microsave.org.

² www.mixmarket.org viewed on 21 April 2006.

low-income households save in institutions that do not consider themselves MFIs, and therefore do not report to the MIX, but generally there is a lack of institutional savings services for the poor for a number of reasons:

- Regulatory obstacles make it difficult to obtain a licence to accept deposits
- The political economy of development rewards donors and government departments for spending their budgets, creating the incentive to promote credit rather than savings initiatives
- Related to the above point, donors keen to spend their budgets often provide wholesale loans to MFIs at rates of interest much lower than the rates they would need to pay depositors, thus undermining MFIs incentive to attract deposits
- The development agenda has assumed that microenterprise credit was a key missing ingredient in economic development
- Many providers consider savings mobilization as a costly way of assembling capital
- There is a continuing widespread belief that poor people cannot or do not wish to save
- Generally, there is a lack of facilities for saving in a secure and cost-effective system

Today, these perspectives are being reconsidered and revised. Many countries have new or prospective regulations for micro-savings. Providers of financial services and their backers, increasingly aware of the benefits of savings for their institutions and their clients, are busy improving their systems to enhance efficiency and build trust with the market. Research continues to reveal high levels of demand for savings services among poor households. However, for the time being, many would-be low-income savers are inadequately served.

Furthermore, many problems associated with savings services become magnified with long-term products – as opposed to open-access “passbook” or “demand deposit” savings. Regulators are especially concerned when institutions attempt to hold what are often the life savings of clients. A high level of trust is required to induce clients to part with their savings for five years or more, and trust in financial institutions is often not high in countries that have witnessed currency collapse, failed financial institutions, inadequate capital markets, hyperinflation and *coups d'état*. In such unstable environments, it may not be feasible to offer long-term savings products. Even in countries with macroeconomic and political stability, financial institutions are often weak or relatively new and fragile.

Long-term savings products are of interest to low-income households as they want to set aside money for future education, marriage, retirement and other major expenses. Discipline is an important requirement. Research conducted on compulsory savings schemes such as Accumulating Savings and Credit Associations (ASCA)³ indicates that members often participate because they like the compulsion to save (Aliber, 2001). Since preserving savings against erosion by trivial withdrawals, or against consumption by relatives, is important to them, low-income people often prefer illiquidity, at least for a portion of their savings.

In some developing countries, savers even pay to save. For example in Ghana, door-to-door agents known as *susu* collectors collect deposits and charge for their services. Similar devices have been found in India and elsewhere in Asia (Rutherford, 2000). The idea that there are costs associated with savings instruments, and that one may not get back all that one has put in, is not necessarily strange to the poor. Indeed, to assess the value of a product from the client's perspective, one needs to consider the transaction costs associated with making a deposit, along with the opportunity costs – where else could they have put their money, and what is the return from those investment opportunities?

In a situation where there is a demand for long-term savings by the poor, but few providers of such services, it is useful to consider insurance companies as a possible option. Insurance companies have long provided contractual savings products combined with insurance. However, these are often inefficient products, as the insurance company's operating expenses are high and are hidden from consumers. There is concern that, for example, traditional endowment products, which combine savings and insurance, have high expense ratios, depend on high lapse rates and generally do not provide value to the insured.

It is unclear, however, if this performance is inevitable, or if there is a delivery method that removes the high cost and provides security and value to the client. Many traditional insurers have used long-term products as their primary source of profits; indeed, many insurance professionals feel that these products are necessary for viability. However, others have developed insurance organizations that sell cost-effective products providing value to the client. The next frontier is to do so while serving the low-income market.

³ ASCAs are informal groups of small numbers of people who save together on a regular basis; most ASCAs offer members loans from the accumulating funds. With ROSCAs, groups of people save together and the pool of funds rotates with each member taking turns to have access.

2 Long-term savings and insurance products for the poor

Based on the case studies and other literature, there are several different ways of offering long-term savings and insurance, including 1) annuities, 2) endowments, 3) savings completion insurance and 4) long-term savings on their own.⁴

2.1 Life annuities

With life annuities, the policyholder or annuitant pays regular premiums until a specified date, usually their retirement date. In many countries, life annuities are referred to as retirement annuities. They do not, however, need to be linked to retirement; they can be linked to any date accepted by the insurer. From that date, the policyholder receives payments from the insurance company until he or she dies. There are variants of this. In a reversionary annuity, for example, the insurance company will continue to pay out to the policyholder's spouse after his or her death, for the lifetime of the partner.

Life annuities, like any other insurance product, work on a pooling principle. An annuity population can be expected to have a distribution of life spans around the population average, so those dying earlier will support those living longer.

However, for annuities to work, the insurer needs accurate data for the population's age and mortality tables (along with other comprehensive demographic data) and must have actuarial expertise to predict future average life spans. This is a difficult enough task in developed countries with good data and in developing countries, the task is many times more difficult. In many microinsurance schemes, for example, even the age of the clients can be difficult to pin down. Predicting the future is also challenging, as small changes can have dramatic effects on long-term life spans. For example, improvements in the provision of clean water and sanitation, or a successful vaccination or mosquito net campaign can dramatically improve average life spans. This makes pricing annuities very difficult.

Life annuities for the poor have been tried in the Philippines by a leading and well-respected institution, the Centre for Agricultural Research and Development (CARD). However, as shown in Box 18, CARD's "pension" scheme almost led the organization into bankruptcy. CARD started offering insurance with a Members Mutual Fund (MMF) designed to provide loan balance coverage plus burial assistance in the case of borrower death. This

⁴ A fifth option, life savings insurance, which is not necessarily long-term although it could be, is discussed in Chapter 2.3.

was a fairly straightforward insurance product. Success, and growing reserves, led the organization to introduce additional products and additional complexity.

Box 18

CARD's foray into annuities

In December 1996, recognizing the need of its older members for pensions, and (over-) confident after the apparent initial success of the MMF, management decided to expand the product coverage. CARD decided to offer a pension benefit to members reaching sixty-five years of age for only US\$0.05 more per week. The additional five cents meant that for both insurance and a pension, the new compulsory contribution was US\$0.10 per week. This pension scheme was implemented across the membership without testing and without actuarial input.

When the client reached 65, or became permanently disabled, the new product offered a lifetime monthly pension between US\$5.45 and US\$10.90, depending on how long the annuitant had been a CARD member. Under this arrangement, it took 14 months of monthly premiums of US\$0.40 from a member to accumulate the lowest pension amount of US\$5.45. There was no minimum participation period before the pension was available; members just had to turn sixty-five years old, although newer members would only receive the minimum pension.

During the 1998 audit, CARD's external auditors advised management that the pension situation was financially unsustainable. They had noted the liabilities building up under the MMF. Based on the auditors' insights, management realized that this liability was a very serious threat. Even though the average age of a CARD member was 43.6 (37.1 in 2004), the potential volume of soon-to-be pensioners would quickly deplete CARD's capital. The pension fund would destroy all the progress CARD had made, and indeed would destroy the institution itself. CARD eventually managed to extricate itself from its liability and shut the scheme down repaying all premiums into a new and separate mutual benefit association owned by CARD members.

Source: Adapted from McCord and Buczkowski, 2004.

The CARD pension scheme was operational from 1996 until 1999. The premiums paid into the pension scheme were then used to capitalize a separate mutual benefit association (MBA) that offered instead a savings plan with a single payment benefit at the end of the term, without an insurance component.

This case illustrates the potential disaster awaiting an institution that enters the risky world of insurance without the proper expertise. Indeed, the new CARD MBA is managed by an insurance professional, and the MBA has worked extensively with an actuarial consultant. This case also highlights the twin obstacles of insufficient data and difficulty of predicting changing mortality rates in developing countries.⁵

Organizations attempting annuities require mortality risk expertise and investment management skills, such as asset liability matching. Any saving facility with long-term guarantees should be reviewed by an actuary and managed to ensure viability. Above everything else, anyone considering entering the micro-annuity market needs to be certain that they have sufficient actuarial data. As this tends to be in short supply in developing countries, such products are not recommended at the moment. Should the situation change and the quality of actuarial data improve, then annuities may be worth reconsidering.

2.2

Endowment policies

Endowment policies, commonly sold by insurers, combine life insurance and long-term contractual savings. They involve a regular payment paid over a long term, usually five years or more. If clients survive the term, they receive a lump sum and perhaps a bonus; if the policyholder dies before the end of the term, and is up to date with premium payments, then the beneficiary receives the sum assured. A particularly interesting feature of endowment policies is that they can also facilitate access to credit, since clients can borrow against the surrender value of the policy. This combination of savings, credit and insurance could be an effective instrument to assist low-income households in managing a variety of risks if it were designed and delivered cost-effectively.

Endowments are already sold in large quantities to low-income clients. In South Africa, it was estimated that at the end of 2004, 300,000 low-income persons held endowment policies (Smith and Melzer, 2004). Delta Life (Bangladesh), Tata-AIG (India) and ALMAO (Sri Lanka) all sell endowment policies to the poor with mixed results in terms of demand, feasibility, and profitability. These companies are all regulated insurance companies, albeit with different agendas.

⁵ In developing countries, mortality rates can decrease tremendously through greater use of *existing* health technology, e.g. vaccinations, effective sewerage systems and water purification. In developed countries, the scope for improving mortality through *existing* health technology is more limited. Of course, in both developed and developing countries *new* technology can greatly improve mortality rates rendering annuities actuarially difficult in any context.

When Delta Life commenced business in 1986, it was one of the first private insurance companies in Bangladesh (following privatization in the mid-1980s). Initially, it sold high-end policies, but very quickly began to complement these with microinsurance. Its mission in selling these products had been explicitly social. It hired insurance professionals to run its high-end operations, and staffed its microinsurance business with social workers. In 2002, the board of directors professionalized the microinsurance business so that it is now focusing more on profitability. However, regardless of its commendable motive, Delta has been criticized for offering a product that delivers inadequate benefits to poor clients; it is slow to pay claims and more than half of its policies have lapsed.

Tata-AIG initially moved into microinsurance because, like all Indian insurers, it was legally compelled to serve low-income and rural policyholders. Even though this market may not be as profitable as other insurance lines, it soon realized it brought advantages, including improved brand recognition, market expansion and fulfilling social responsibility obligations.

Table 12

Two insurers with endowment products

<i>Institution</i>	<i>Tata-AIG (US\$)</i>	<i>Delta Life (US\$)</i>
Country	India	Bangladesh
GDP per capita (2003 UNDP)	564	376
Name of policy	Karuna Yojana	Endowment (with profits)
Term	15 years	15 years
Premium	6.67 per year given characteristics noted below under "Benefits" (includes savings and insurance premium)	6.33 per 100 sum assured (includes savings and insurance premium)
Benefits	If taken out at age 18 – sum assured 556, maturity benefit 112	85 to 1,650 Other benefits: after two years eligible to borrow up to 90% of cash value for one year at 20% per annum from Delta.

ALMAO started in 1991 as an informal insurance scheme of the Sanasa network of savings and credit cooperatives, offering basic products covering death, disability and hospitalization. ALMAO also offered the Sanasa societies services like loan protection, life savings and property and health insurance for employees. In 2002, ALMAO was formally registered as a life insurance company. This change of status encouraged the insurer to introduce a

new range of endowment products that are professionally priced and managed. Unfortunately, the products do not appear to meet the needs of the target market as there has been very little demand for them thus far.

As vehicles for collecting the long-term contractual savings of the poor, endowment policies are controversial. In many countries, endowment policies do not provide good value, as expenses are high and payouts low relative to other instruments. They tend to be relatively expensive to sell because they are sold individually rather than to groups, which adds considerable expense, particularly in the form of sales commissions. The commission structure also tends to encourage sales practices that are not within the spirit of microinsurance (*see Chapter 3.2*). Endowments are complex products to design and manage. With small sums assured, costs are sometimes covered by providing the policyholder with comparatively little value. For example, many if not the majority of poor policyholders receive substantially less cash back than they paid in premiums because they have not been able to keep up with their payments. For endowment products to benefit the low-income market, these and other obstacles will have to be overcome.

2.3 Savings completion insurance

A third way of addressing the long-term savings and insurance needs of the low-income market is through savings completion insurance. TUW SKOK, the primary provider of insurance to Polish credit unions, offers such a product to encourage credit union members to develop a regular savings programme. The member determines the savings goal and time period, up to a maximum of 10 years. The credit union has software that will then calculate the amount of the monthly deposit to achieve the savings target. The software also calculates the monthly premium for insurance coverage. In the event of accidental death of the member, TUW SKOK will pay the beneficiary the difference between the savings target and the savings balance at the time of death. There is also a disability component that supplements the member's salary if he or she is unable to work for more than 30 days.

This insurance product is of particular interest to the credit unions because it is closely integrated into their core business and helps them achieve their own goals by making the contractual savings product more attractive. It is also easier for credit union staff to sell than stand-alone insurance products because they can ask when setting up the account whether the member wants the additional insurance coverage.

A major difference between the endowment and savings completion insurance is that with the latter, the insurer does not hold the savings – the credit union does. From the insurer's perspective, this is a very simple prod-

uct: just basic term life with a declining sum insured. It may be less attractive to insurers than an endowment product because they would generally prefer to invest the funds and generate additional revenue. However, savings completion insurance may provide better value to clients, since their savings are no longer used to pay the agent's commission. The savings completion insurance is an affordable group policy; for example, TUW SKOK charges 0.07 per cent of the remaining savings balance per month for the coverage,⁶ while the credit union pays three to six per cent per year on the savings balance.

2.4 Separating long-term savings and insurance

A fourth approach is to offer savings and insurance separately. Term life tends to be relatively easy to obtain. Long-term savings can, of course, only be offered by institutions licensed to accept deposits with reputations that motivate their clients to trust them. As mentioned earlier, the supply of such services is limited, but there are some important examples of institutions offering long-term contractual savings (*see Box 19*).

Box 19

Grameen's deposit pension scheme (GPS)

As part of "Grameen II" – the wholesale redesign of its products that Grameen Bank established in 2001 in a bid to recover from declining performance in the 1990s – Grameen began to offer one of the world's largest and fastest-growing long-term savings products for the poor. It is based very closely on an extremely popular product that has long been offered to wealthier Bangladeshis by the country's commercial banks, offering further evidence that it is shortcomings on the supply side, rather than on the demand side, that constrain the use of such services by poor people.

Terms are five or 10 years, and equal monthly deposits are made in sums as little as US\$1. Interest on the 10-year scheme is paid at 12 per cent p.a. (about 8 per cent p.a. in real terms and rather generous compared to rates offered by commercial banks for similar products, leading to a sudden new demand from non-poor households to obtain Grameen membership). The matured sum may be taken in cash, or as monthly income (not an annuity, merely the interest income on the sum at 12 per cent p.a.). Savers may also transfer the sum into one of Grameen's attractively priced fixed deposit schemes. There is no insurance element, and no evident demand for it to be added.

⁶ If the savings objective is 1,000 and current savings are 900, the difference of 100 is insured for an annual premium of 0.84.

Deposits are made during the weekly meeting that all Grameen members are obliged to attend. Grameen thus uses its own “agents”, and does so extremely economically, since the agents are also responsible for servicing the loan portfolio.

Now five years old, the scheme has attracted more than 3 million accounts, and the total GPS portfolio held by Grameen at the end of 2005 was approximately US\$83 million. The GPS has been one of the main elements in converting Grameen from a microcredit provider into a true financial intermediary: its total savings portfolio, from all savings products, is now US\$450 million and exceeds its loan portfolio.

Understanding precisely why the scheme is so popular is complicated by the fact that all borrowers with a loan of more than US\$125 are required to hold a minimum-value GPS account. Nevertheless, many accounts have balances above this minimum, and many savers hold more than one account, suggesting that the scheme is valued for its own sake – a finding reinforced by testimonies taken from savers for a MicroSave-funded research project.

Source: Rutherford, Personal notes based on research done for MicroSave, 2005.

CARD Bank ended up offering long-term contractual savings after its disastrous experience with annuities. Instead of worrying about the complexities of insurance, it created a provident fund into which all members pay PHP 5 (US\$0.09) per week. When they reach 65, they are guaranteed a single payment based on the value of deposits received plus accumulated interest (currently at 8 per cent per annum).

Relative to the other options discussed above, for clients the main advantage is that they can save without needing insurance. Yet that is also the disadvantage. If they die or are disabled during their savings-generating years, they (or their families) will not have anything to fall back on. If they do want insurance to complement the savings scheme, they may be able to shop around. However, when seeking individual coverage, they are not likely to find a more affordable option than a term policy offered by the organization that takes their savings (ideally underwritten by an insurer).

3

Key issues in offering long-term savings and insurance

When long-term savings and insurance are offered to the poor, several issues need to be carefully considered, including macroeconomic and political stability, financial sector infrastructure, mis-selling, premium collection mechanisms, lapses and surrender values. Some of these challenges affect endowments more significantly than the other savings products.

3.1 **Macroeconomic and political stability**

For any financial instrument intended to retain value into the future, macroeconomic and political stability is a key concern. Many people from around the world, rich and poor, have awakened one day to realize the money they had saved was now virtually worthless. The culprits: inflation and/or devaluation. These risks are not trivial. The AIG Uganda case study relates a story of a man who paid his premiums as required and waited until the endowment had reached full maturity. When he arrived at the insurance company office, his payout was less than the cost of the bus ticket he bought to come to town to collect the benefit.

In unstable economies with high inflation, it is particularly difficult to offer long-term savings and insurance. There are, however, ways to manage inflationary risks. For example, the financial institution could offer foreign currency accounts and make international investments. Established insurance companies may be better placed than more recent financial intermediaries to carry out the complex transactions required to hedge effectively against inflation. Interest rates or investment returns are sometimes inflation linked, with deposits, premiums and benefits increasing based on inflation.

The financial situation of low-income people is precarious. If policies with long-term investment components are to be sold to this market, the policies should be developed to provide protection from macroeconomic instability and real value to clients. All economies are subject to unforeseen inflation; product design has to develop returns to policyholders to protect them from the ravages of inflation. If insurers cannot achieve that objective, then clients should be encouraged to save in assets that retain their value, like livestock or gold, and to explore short-term insurance coverage to manage risks.

3.2 **Financial sector infrastructure**

Another important requirement for long-term savings and insurance is for there to be an effective investment or capital market in the country. Long-term savings can be beneficial to all if the institution receiving the funds can invest in a variety of instruments for varying lengths of time. Investment in bonds, treasury bills, equities and property would be possible forms of long-term savings to the extent that they match the desired investment time frame. The ability to rate the investments would also be required to assess their risk profile. In some countries, these conditions do not exist, making it difficult to properly manage long-term savings.

A lack of financial sector infrastructure has a greater effect on endowment products than on savings completion or savings alone because the insurer relies more on the investment market for returns. If there are limited investment opportunities, and it is difficult to assess the risk of the few opportunities that are available, it will be particularly difficult for endowment products to succeed. The credit unions or Grameen Bank on the other hand invest a significant amount, if not all, of their savings in the associated loan portfolio. Although this creates an ill-advised concentration risk (*see Chapter 3.6*), such investments do not require stock exchanges or rating agencies.

3.3 Mis-selling

Another problem with long-term products is the potential for mis-selling, since the client is not able to effectively assess whether the financial institution and its agent are indeed trustworthy for some time, sometimes years, after they have purchased the product. This issue is much more problematic for endowment policies (*see Box 20*) than savings schemes because the latter are more transparent. In addition, the staff “selling” savings products are unlikely to earn an individual commission based on savings volumes, so they do not have the incentive to misrepresent the product or press persons who are not interested to buy it.

Box 20

Mis-selling in South Africa

The Black Sash is a South African human rights organization which runs community advice bureaus that assist with a range of consumer protection issues. Many of the cases taken up by the Black Sash involve the agents of insurance companies who sell a plethora of insurance policies, including endowments, to rural consumers. A fairly typical case involved a domestic worker in a local government agency.

Until her retirement in March 1993, she earned US\$162 each month. She paid US\$37 per month for insurance policies from four major insurance companies. After her retirement, all she received from her numerous policies was US\$58. She went to the Black Sash for assistance.

In this case, after a long struggle involving many months of correspondence with insurance companies, she eventually received US\$169 in total (from surrendering policies). One policy was surrendered when she retired, four years before the policy became due. She was “assisted” by the personnel officer of the government agency she worked for, who failed to inform her that if she waited until the policy became due she would have received much more.

Source: Adapted from Roth, 1995.

Mis-selling can be a major problem, even in countries with highly-regulated financial markets. In the UK, it has been estimated that 5 million people were mis-sold endowment policies.⁷ For the most part, these persons bought endowment policies together with a mortgage believing that the endowment policy would pay off their loan when the endowment matured, but that did not happen. The UK Treasury Select Committee which investigated the problem estimated a nationwide shortfall of £40bn (US\$69.6bn)

One needs to bear in mind that while it may be in the agent's interest to mis-sell policies (depending on the structure of the sales incentive), it may also be in the interest of the insurer, especially if the policy lapses. Some insurers rely on lapses in latter years to avoid paying benefits. Endowment plans designed to rely on lapses can be beneficial to the few clients who have the ability to maintain premiums, but they are of poor value for the majority of clients. Fortunately, with consumer pressure in some countries, some insurance companies have been forced by regulators to pay out hundreds of millions of dollars to misled consumers. This has not only been costly, but has proved a public relations fiasco for insurers.

3.4

Savings and premium collection methods

A key issue with all products is minimizing the costs of collecting savings and premium payments; otherwise the savings of the poor will merely be paying the operating costs of the provider. One way to reduce costs is to reduce the frequency of payments, but for the low-income market it is reasonable to assume that periodic payments (weekly, monthly or quarterly) are probably more appropriate for their cash flow than annual payments (*see Chapter 3.3*).

With long-term savings and insurance products, there are three general models in use for premium collection: electronic deductions, micro-agents, and linking the product to another financial transaction.

Electronic deductions: In countries where low-income persons have bank accounts, premium payment may take place electronically, with follow-up occurring only if the deduction fails. This is how endowment policies are sold to the poor in South Africa, where poor households often have one member with a formal sector job and bank account. Under present conditions, this model would be inappropriate for many low-income countries, although as new technologies emerge and banking changes, new opportunities may arise, for example premium deductions through cell phone banking.

⁷ Ref: <http://www.which.net/endowmentaction/index.html>

In the Philippines, deposits can now be made via cell phone for a charge of 1 peso (US\$0.02) per transaction, which is considerably lower than the transport costs incurred to visit a financial institution (Chemonics, 2006).

Micro-agents: In India, Tata-AIG first began working with an MFI to sell its policies. The relationship did not work because the short-term nature of the MFI's loan conflicted with the long-term nature of the endowment policies. It was, therefore, difficult to collect premiums from clients who took out an endowment policy but only a single loan. While it is relatively easy to deduct a premium from the disbursed loan, if the client stops borrowing, then a new mechanism for premium collection is required. Tata-AIG therefore turned to individual agents, primarily low-income women, who are formed into Community Rural Insurance Groups (CRIGs) that operate as an insurance agency. These agents would view their income as supplementary and would be prepared to work for relatively low commissions. Tata-AIG's model is discussed in more detail in Chapter 4.5.

Delta Life and ALMOA also rely primarily on poor housewives as their army of agents. Indeed, the basic element of door-to-door premium collection is the same for all three organizations. Such an approach may work in the Indian subcontinent where population densities are high and many people with sufficient levels of education are prepared to work for a low wage. It is unclear whether this model could apply to countries with lower population densities and low levels of formal education.

Linked payments: In the examples from CARD, Grameen and TUW SKOK, the costs of savings collection are minimized by linking with another financial transaction. The CARD and Grameen clients make their savings payments in the same weekly group meetings, generally located very close to their home, where they make loan repayments. At TUW SKOK, when the member makes her or his monthly deposit, a small amount is automatically deducted and at the end of the month accumulated with all the other premiums that the credit union needs to pay to the insurer.

3.5 Lapses and the problem of surrender values

Another problem, which is very specific to endowment products, is lapsed policies. With the savings products, if depositors miss a payment or stop depositing, they may earn a lower interest rate, but they will not lose their savings. If a policyholder stops paying the premium on an endowment policy, however, it will lapse and only the surrender value – often only a small part of the savings – is returned to the client. Given the irregular incomes of

low-income households, lapsed policies are a very significant problem for microinsurance.

The limited surrender value in the early years is related to the upfront remuneration of the agent along with other costs of initiating a policy, such as screening, data entry and contract preparation. Agents tend to receive their commission in the first few years of the sale (*see Chapter 3.2*). In a lapse situation, these costs are deducted from the savings component and the remainder is returned to the client. In the first few years of the policy, there is usually no surrender value at all.

There are various ways to deal with the issue of lapses. Delta allows a thirty-day grace period for late payments, after which time the insurance component is suspended. Policyholders can refresh the policy within 12 months if they pay a late fee and undergo an underwriting review. Policies can even be revived after two years with a late fee plus medical report showing acceptable health. Besides introducing an unsuccessful microenterprise loan product to help policyholders generate income (*see Chapter 3.3*), Delta has not adapted the endowment concept to deal with the realities of the low-income market where irregular cash flows are to be expected; furthermore, with low sums assured, a medical report should not be necessary. In contrast, if Tata-AIG's policyholders are late with their premiums, the insurer deducts the premium from the amount accumulated in the surrender value. This seems to be a more accommodating approach for the low-income market.

More innovation is required to deal with the problem of lapses. Perhaps an area to be explored would be the creation of incentives for regular payment, e.g. a bonus if all premiums are paid within five days of becoming due and a reduction in benefit if payments are not made, rather than a simple termination of cover. The crucial issue is that the surrender values must be fair, and clients aware of the policy conditions including the surrender value. Fairness in this instance would mean that the savings and insurance portions of the premiums are understood by the policyholder, and that income or expense adjustments are clearly understood prior to the purchase of the policy.

4

Conclusions

Long-term savings and insurance provide an exciting new opportunity to expand the frontier of finance. The demand is there. The challenge is to find the right product design, delivery mechanism and institutional arrangement to address that demand in a cost-effective way that provides value. Of the three products analysed in this chapter (since annuities were not considered viable for the time being), from a purely product design perspective, it

appears that the two products that separate savings and insurance (or do not include insurance) have a substantial advantage over endowment products.

Institutionalized savings services are not widely available to the poor, and if they are available, they may be provided by organizations that are not sufficiently solid or credible to offer long-term savings. Consequently, insurance companies are well placed to offer an alternative, an endowment product, which may also appeal to poor households if designed to accommodate the characteristics of, and provide value to, the low-income market.

The main findings of this chapter are as follows:

- Financial institutions have been slow to offer long-term savings to the poor because of regulatory hurdles, macroeconomic instability, underestimation of the demand for, and the costs of, providing such services, and a lack of consumer trust. These obstacles can be overcome, and in some countries progress is being made, but for now, most low-income households lack access to long-term savings services despite strong demand.
- Insurance companies could play a role in overcoming many of the difficulties associated with long-term savings, either on their own or in partnership with a grassroots financial intermediary, like a credit union or other type of micro-finance institution.
- Annuities are not easy to develop for low-income clients in developing countries; these products are not currently recommended due to actuarial difficulties, and the substantial mortality and investment risk.
- All long-term savings and insurance products are difficult to offer in unstable political and economic environments.
- It appears that endowment products currently sold to low-income clients have not yet been designed to provide substantial value to the policyholder.
- The principal difficulties with endowments are: (i) ensuring that premiums can be cost-effectively collected over long time-spans, requiring innovative collection systems, (ii) low surrender values resulting in the policyholder receiving back only a fraction of premiums paid and (iii) mis-selling, a problem that has been rife even in developed economies.
- Donors and development agents should only recommend endowment policies in countries where they can be effectively regulated and where reasonable value is provided to clients compared to that offered by other savings vehicles.
- Instead of endowments, a better solution may be to combine the savings component of an MFI with an insurance benefit. This would have the simplicity of providing an insurance incentive to clients who save.

To expand the availability of long-term savings and insurance products, insurers, bankers, donors and development agencies can play a significant role in improving the design of products for the poor, helping regulators to oversee them, and strengthening consumer protection mechanisms to ensure that the products are fairly designed and honestly sold.

None of the currently available products are flawless. Indeed, additional innovation is required to provide better long-term products for the low-income market. Such innovations would need to be evaluated on their own merits. Are they safe, protected from inflation and well regulated? Do they provide real value for clients?

2.3

Savings- and credit-linked insurance

Sven Enarsson, Kjell Wirén and Gloria Almeyda

The authors appreciate the inputs and suggestions provided by Jean Bernard Fournier and Catherine Tremblay (DID) and Ellis Wohlner (consultant to SIDA).

Villages in developing countries have traditionally provided residents with simple forms of risk sharing or insurance. Whole villages, clans or voluntary groups have assisted members affected by shock. In many countries, funeral aid groups represented an early form of voluntary insurance. People formed associations which assisted the family of a member when somebody died. The assistance could be in cash or in kind, and often the main part of the support was for the funeral, which was an expensive event. Some groups accumulated savings to meet the expenses, while others collected funds at the time of the death. The cases of accumulated savings show that the connection between savings and insurance has a long tradition.

Formal savings and credit cooperatives emerged to serve low-income people in the early decades of the 19th century. Since the normal financial system did not reach this market, the poor created their own institutions. These cooperatives reached many people, in cities and towns, as well as in rural areas. Savings and credit cooperatives often offered emergency loans, which functioned as a simple risk-management service for the members. At a later stage, loan protection insurance was introduced and became one of the earliest forms of microinsurance, affecting a large number of poor people. The insurance covered the repayment of a loan if the borrower died. An American insurance group, CUNA Mutual, played an important role in the introduction of loan protection insurance in many countries, in particular for savings and credit cooperatives.

In the 1960s and 1970s, a number of schemes were implemented in developing countries to provide credit, primarily to small-scale farmers. Many of the schemes failed to recover loans and there were no insurance arrangements. However, policymakers and donors still saw the provision of credit to the poor as an important means of facilitating development. In the 1980s and 1990s, a number of microfinance institutions were established, often in the form of an NGO, which largely targeted entrepreneurs, not farmers. As

these microfinance institutions matured, loan protection became an increasingly common feature.

Step by step the insurance service provided by savings and credit organizations developed. These organizations, of both the cooperative and NGO type, often added one or two insurance options to the loan protection scheme as an integrated part of their operations, and sometimes carried the risk themselves. Others, instead, chose to become agents of commercial insurance companies (*see Chapter 4.2*). Some savings and credit organizations even established their own commercial insurance companies to offer a wide range of services to their members (*see Chapter 4.1*).

This evolution of the relationship between insurance and savings and credit products boils down to two complementary dimensions:

1. Financial intermediaries want insurance to protect their loan portfolios.
2. Since they already have financial transactions with the target market, it is very cost-effective for them to offer low-income households insurance services linked either to their savings or to credit products.

This chapter is mainly based on ten case studies of savings and credit organizations involved in the provision of microinsurance. The studies cover many different environments, conditions and types of service delivery. Although other savings and credit organizations may provide microinsurance services a little differently, the ten cases cover the important aspects of savings- and credit-linked insurance.

The abbreviation MFI is used for all types of savings and credit organizations that provide financial services to low-income households, including NGOs, microfinance banks, and savings and credit cooperatives. Only when there is a specific reference to savings and credit cooperatives is this term used. Similarly, the term “client” and “member” are used interchangeably to refer to the person buying insurance or being protected.

I **Loan-linked products**

A range of insurance products could be linked to loans. Where the insurance products are designed and managed by the microfinance institutions themselves, the products tend to be simple and closely related to the credit services. Where there is a closer involvement of a professional insurance organization, services are generally more attuned to the needs of the clients, and correspondingly less related to the savings and credit operations.

It should be noted that numerous MFIs only offer loan services to their members. They do not accept deposits. These MFIs are naturally inclined to offer only insurance services which are directly related to the loans. When the loan is repaid, the MFI has no business transactions with the client and the insurance coverage also ceases.

1.1 Loan protection

Many MFIs have introduced loan protection insurance, also called credit life, to achieve two objectives: 1) to cover the loss that an organization may incur upon the death of a borrower and 2) to relieve the borrower's family of the burden of repaying the remaining loan, hence ensuring that "the debt dies with the debtor". Compared to the other products discussed in this chapter, loan protection provides the most limited coverage to the client or beneficiaries; yet it is also the most affordable and often a compulsory part of the loan.

A common way to operate a loan protection scheme is for MFIs to integrate insurance into the loan, which simplifies the administration. As the scheme is mandatory, there is little risk of adverse selection and there is no need for additional staff since premiums are paid through the loan, normally as a slightly higher interest. The aspects of loan protection coverage are fairly common across the different organizations. The key distinguishing features are:

1. *Who carries the risk?*

Some MFIs carry the risk of their loan protection scheme themselves. This may be somewhat hazardous since an unregulated insurer cannot obtain reinsurance. In an unregulated insurance operation, there is also a risk that the interest of the policyholders is neglected, although in reality, if the MFI fails, the clients probably will not need loan protection cover anyway. It is when the insurance provides other benefits besides loan cover that the consumer protection concerns become warranted. Another concern with the MFI carrying the risk is that the insurance funds may be inappropriately mixed with funds from the savings and credit operations. The advantages and disadvantages of self-insurance are explored in more detail in Chapter 4.7.

2. *What risks are insured?*

Besides covering the borrower's death, loan protection can also cover permanent disability and illness. Inclusion of such coverage for the low-income market may cause problems and needs careful preparation and well-designed terms and conditions (*see Chapter 3.1*).

3. *What is the price?*

It is a little difficult to assess the price of loan protection by itself because the rate can be quoted in many different ways. Columna, in Guatemala, charges the cooperatives 0.71 per Q. 1000 per month. In Zambia, Madison's coverage ranges from 0.8 per cent of the loan amount for four months for FINCA, to 3.5 per cent of Pulse's loans that are longer than one year. OIBM in Malawi pays 0.35 per cent of loan principal per month of the loan term, whereas at Opportunity International in Mexico, the premium is calculated as $((0.0039 \times \text{loan principal} / 52) \times \text{loan term in weeks})$.

These examples indicate that the insurance fees in terms of effective interest on an outstanding loan balance may vary from less than 1 per cent to more than 8 per cent. The varying terms and conditions may justify different fees, but the high fee variation calls for improved regulations, research and actuarial analysis.

4. *What is the sum insured?*

A comparison of the fee rates is also complicated by the fact that the sum insured differs from one scheme to another. Columna covers the **outstanding loan balance** and accrued interest, which is perhaps the most typical loan protection benefit. At FINCA Zambia, loan protection from Madison Insurance covers the outstanding loan, which includes interest because interest is charged at a flat rate and added to the loan balance when the loan is disbursed. However, for the two Opportunity International affiliates and CARD MBA in the Philippines, the sum insured is the **disbursed loan amount**. OI prefers this approach because the lender is guaranteed cover for the full outstanding balance regardless of whether or not the loan is in arrears on the date of death. The other attraction of purchasing credit life on the disbursed amount is that it leaves a balance, sometimes substantial, for the beneficiaries.

5. *Is it combined with other benefits?*

Loan protection may be of great value to a family after the loss of a member who might have been the breadwinner. A crucial shortcoming is that the cover only facilitates loan repayment, whereas the need to manage risk is much wider in poor families. Consequently, as described below, the value of loan protection can be improved by offering additional benefits as long as they are also easy to administer.

Loan protection is a rudimentary form of insurance, often the first type of formal insurance encountered by poor people in developing countries. If it is properly implemented with comprehensive awareness campaigns, it can

improve knowledge about insurance among the target population. Unfortunately, from the experiences in the case studies, clients (and the beneficiaries of policies) do not always know that they have this protection, and therefore by itself, loan protection does not automatically contribute to creating an insurance culture. The importance of involving the clients in the design of the products and providing them with information and training cannot be over-emphasized. Another way to overcome some of the disadvantages may be to offer mandatory life insurance with a loan instead of pure loan protection, as described in Box 21.

Box 21

Life insurance as an alternative to loan protection?

Instead of loan protection, some MFIs offer mandatory life insurance with the loan. For example, ASA in India has offered insurance in one form or another for more than a decade, but has never offered credit life. Instead, its basic term life insurance policy (now offered on behalf of three different insurance companies, each responsible for the clients in different branches) provides a flat benefit of Rs. 20,000 (US\$222) to the beneficiary in the event of the borrower's death. Upon receiving the benefit, the beneficiary is responsible for repaying the loan (less any savings held by the MFI).

The disadvantage of this approach is the extra transaction that must occur when a claim is made. Instead of the MFI being paid directly by the insurer, it must collect from the next of kin. The advantage, however, is that it is a more transparent approach. Borrowers are more likely to know that they have bought insurance and to know how much they paid for it.

Perhaps most importantly, this approach has a much stronger demonstration effect than loan protection because it creates an opportunity for a public ceremony to provide the beneficiary with the insurance payout. All the members of the deceased's self-help group, and many people in the community, can see first hand the insurance company fulfilling its contractual obligations – basic loan protection does not provide such an opportunity to plant the seeds of an insurance culture.

Source: Adapted from Roth et al., 2005.

If life insurance is offered instead of loan protection, the sum assured should be more than the loan amount. Since the size of loans may vary considerably, there should be a choice of benefit levels in the life insurance. The procedure for recovery of the loan balance can also be simplified by securing the client's permission for the benefit to be channelled through the MFI for repayment of the loan. A payout ceremony to promote the life insurance scheme can still be arranged for the balance of the benefit. From a marketing

perspective, this may even be more attractive since it eliminates the need to recover the loan balance from a sum already paid out in public.

A great advantage of a separate life insurance is that it facilitates a continuation of the insurance. The disconnection of the insurance from the loan means that it will be natural to explain terms and conditions of the insurance to the client and to agree on a system for payment of the fees after the loan has been repaid.

1.2 Loan protection combined with funeral aid

The most common additional benefit in loan protection schemes is **funeral aid protection for the borrower**. Besides the repayment of the loan, the insurance provides a benefit to the family of the deceased to meet funeral costs. Usually, the benefit is equal to the original loan amount or to the remaining loan balance, or for another fixed amount. Sometimes the benefit for an accidental death is higher than for a natural death.

The coverage of funeral aid insurance is sometimes extended to cover the death of non-borrowing family members as well.¹ Besides assisting the borrower in a difficult situation, this arrangement also facilitates his or her continued loan repayment. Therefore, indirectly it also benefits the MFI. The microfinance institution (or its insurer) also benefits because the family approach increases the number of persons covered, including low-risk persons such as children over five. Since the client joined the MFI to access savings and credit services, not to get insurance, the risk of adverse selection for family members is reduced. However, if the funeral aid coverage of family members is not a compulsory part of the loan protection scheme, there is a risk that borrowers with sick or near-to-death relatives will opt for this additional coverage to a larger extent than borrowers with a healthy family.

Although funeral aid is mainly a benefit for the borrower and his/her family, it is often compulsory because it is coupled with loan protection. This is a cheap and effective administrative option for savings and credit organizations; however, there is little room for flexible solutions that take into account the explicit needs of the individual members.

CARD MBA has introduced an All Loan Insurance Package, which is mandatory for borrowers (*Table 13*). Upon the death of a borrower, besides repaying the remaining loan balance, the benefits include the payment to a designated beneficiary of an amount equal to the already repaid instalments. In addition, a spouse and up to three children are covered by the family

¹ In Churchill et al. (2003), funeral aid protection for the borrower is referred to as Additional Benefits, while coverage for other family members is called Additional Lives.

funeral insurance benefit; alternatively, if the member is single, his or her parents can also be covered. To keep the risks of covering spouses and even parents under control, CARD MBA offers lower benefits for new clients and their family members.

Table 13

CARD MBA's loan protection plus family funeral insurance

<i>Product features and policies</i>	
Microinsurance type	Compulsory life insurance
Group or individual product	Transactions between members and the MBA are all managed through the bank or NGO. In this sense, it acts as a group policy. However, in terms of the legal structure, an MBA must provide individual policies to each insured and track them as individuals.
Term	Renewals match loan renewals.
Product coverage (benefits)	<ul style="list-style-type: none"> · Disbursed value of the loan · Single payment at death or total and permanent disability of member, legal spouse, legitimate children (21 and below, or if above 21 must be incapacitated or disabled; maximum of three children covered), legitimate parents over 60 years old if the member is single.²
Key exclusions	One-year contestability period
Pricing – premiums	Loan protection: 1.5% of disbursed loan amount per annum Family funeral insurance: PhP 5 per week (US\$0.09)

Source: McCord and Buczkowski, 2004.

1.3 Loan protection combined with other benefits

To enhance the value to the client, as mentioned earlier, other benefits can also be added to loan protection. AIG Uganda offers an extended loan protection scheme that covers, as usual, the remaining loan balance in the case of non-accidental death. In case of accidental death, besides repaying the balance of the loan, the insurer pays a minor lump sum to the beneficiary.³ The loan balance will also be repaid in the event of **permanent disability**. Finally, it has added an element called “**catastrophic cover**” to the policy, which

² As illustrated in Table 21 in Chapter 3.1, the actual benefit ranges between US\$18 and US\$665 depending on how long the borrower has been with CARD, whether the death was natural or accidental, and whether a borrower or another family member died.

³ No funeral benefit is paid in the event of a natural death because AIG has a non-life insurance licence.

repays the client's loan if fire damages numerous microenterprises (but does not help with rebuilding).

At TYM in Viet Nam, besides covering the outstanding loan and providing a small family funeral benefit (US\$32 for members, US\$13 for spouse and children), the Mutual Assistance Fund also pays a small benefit to members for **serious illnesses or surgery** – although, as each member can only claim this benefit once in their lifetime, its use is limited.

Madison has added another health-related benefit, **illness cover**, to its loan protection scheme. If a borrower becomes ill, the policy covers the instalments during the illness period, depending on the repayment frequency – 8 weekly, 5 fortnightly or 3 monthly instalments. To claim this benefit, the illness has to be certified by a doctor, which can be an obstacle (*see Box 22*). It does not cover any of the direct health care costs; it ensures that the MFI gets paid, and for clients it reduces the risk of borrowing, but they have to find another way to cover the doctor and pharmacy bills.

Box 22

Illness cover in a credit life policy?

When CETZAM first introduced credit life, the product covered sickness. If the client was ill for a prolonged period, then Madison Insurance would pay up to three monthly loan instalments. Experience showed that it was hard for clients to claim under this provision because they could not provide formal medical records, as required by Madison. As a result, CETZAM negotiated to have the credit life just cover death at a reduced premium.

Source: Adapted from Leftley, 2005.

Loan protection insurance with additional benefits may be an appropriate first step towards extending coverage to the low-income market. Since the basic product is an integrated part of a loan, the transaction costs can be kept to a bare minimum, which allows more of the premium payments to be earmarked to pay benefits.

In practice, however, this type of coverage has had a strong bias towards the lending organization – for example, by paying loan instalments when the borrower is sick or when his house has burned down, but offering little assistance to borrowers to get back on their feet again. Microfinance institutions (and their insurance partners) could theoretically provide more comprehensive benefits, but that would mean larger premium payments, which may be hard to impose on borrowers, especially in competitive credit markets.

Experience, particularly from the savings and credit cooperatives, shows that MFIs should be cautioned against adding benefits without careful and thorough preparation. Indeed, when considering additional benefits, micro-

finance institutions have to assess the demand to understand which benefits would be most useful for members, ensure that the benefits are simple and easy to understand, and ensure that management and staff are involved in the process and that they are rewarded for their work with the insurance service.

1.4 Voluntary life insurance

Besides the mandatory covers associated with loan protection, MFIs can also offer group life insurance on a voluntary basis that is still loan linked. The main reasons for linking these products to the loan are efficiency and affordability. The **efficiency** argument is the same as with loan protection; most of the transaction costs for insurance (e.g., sales and premium collection) are integrated into the lending activities. As for **affordability**, poor families often have difficulty gaining access to cash to pay premiums. When they receive a loan, however, this problem is temporarily overcome. In the actual financial transaction, prospective borrowers are usually asked if they want the cover before the loan is issued, so that the premium can be deducted from, or added on to, the loan amount.

For loan-linked voluntary life insurance, the MFI must agree with clients on a realistic way of paying premiums after the loan has been fully repaid so that the coverage can continue even if the clients prefer to stop borrowing. The clients' full understanding of the future arrangement is necessary to secure a continued risk cover for them.

Besides providing credit life, La Equidad distributes voluntary group life through its cooperatives and a microfinance NGO, Women's World Fund (WWF). The loan officers of WWF sell the insurance product, *Amparar*, when they appraise the clients' loan applications. There are six options based on insured values: from CoP 3 million (US\$1,245) to CoP 20 million (US\$8,290). To enhance efficiency and affordability, borrowers who are interested in the coverage agree to have the amount of the annual premium included in their loans. The annual premium cost for the smallest plan is equivalent to 2.3 per cent of a US\$500 loan. Premiums can also be paid with loan repayments (plans include monthly, quarterly, and half-yearly payments). Yet the scheme faces the common problem of non-renewal for those who do not continue to borrow.

ALMAO in Sri Lanka offers a funeral insurance product for a low premium of less than US\$2 a year. Up to nine persons – the member, spouse, children, parents and in-laws – can be covered under one policy. The benefit, US\$100, is payable upon death of any of the covered persons, although limited to two deaths per year per family. One of the objectives is to use this product as an introduction to insurance for members of Sanasa, a large savings

and credit cooperative movement. The funeral aid insurance is very popular, complementing the services offered by the numerous traditional funeral aid groups in Sri Lanka.

As with the loan protection, life insurance can also be augmented with other benefits that are relevant to the policyholders. At Columba for example, besides its loan protection (discussed above) and life savings coverage (discussed below), the insurer offers a group life product, “*Plan de Vida Especial*” (Special Life Plan) for cooperatives to sell to their members. Although it is voluntary from the insurer’s perspective, 75 per cent of the cooperatives that have joined the scheme have preferred to make the product compulsory for new members to increase volumes and streamline paper work.

For a premium of Q. 63.39 per sum assured of Q. 10,000 per year, the main benefit from the Special Life Plan is funeral expenses, with a sum assured between Q. 10,000 (US\$1,235) and Q. 50,000 (US\$6,173), depending on the age and preference of the insured.⁴ In addition, the policy offers the following additional benefits:

- **Accidental death:** If the death occurs due to an accident, the insured sum is doubled.
- **Special accidental death:** If the death occurs as a result of a “special” accident, e.g. travelling as passenger in public transport, in a lift, or as a result of fire in a public building, the insured sum is multiplied by three.⁵
- **Total and permanent disability:** In the event of permanent disability caused by an accident, the policyholder receives the insured sum.
- **Loss of limbs:** Compensation for the loss of limbs as a result of an accident is paid according to the following schedule of benefits:
 - 100 per cent of the insured amount for the loss of both hands, both feet, the sight of both eyes, of one hand and one foot, or the loss of one hand or one foot together with the sight of one eye
 - 50 per cent for the loss of one hand or one foot
 - 33.3 per cent for the loss of sight in one eye
 - 25 per cent for the loss of the thumb and any other finger on the same hand

⁴ Exclusions for this product include: suicide during the first two years; natural deaths occurring during the first 180 days; and death or disability occurring while engaged in illegal activities. To be eligible, one must be younger than 64 when joining and no more than 74 for renewals.

⁵ Some experts have concerns about special benefits that pay multiples of the sum insured because they can be misused as marketing ploys, when in fact the insurer rarely if ever pays out special benefit claims. Another disadvantage of higher sums insured for accidental deaths is that it increases the costs associated with claims verification, since the insurer or its agent would have to determine if indeed the death was accidental, a process that is often more complicated in poorer communities (see Chapter 3.4).

Similarly, the scheme of Yasiru Mutual Provident Fund in Sri Lanka has built on a life insurance base to add benefits that were developed in dialogue with the membership. Members are divided into four categories depending on their household situation, so smaller households pay lower premiums. Within each category, the member can choose between five different levels of monthly premiums to receive a range of benefits (*see Table 14*).

Table 14 Different benefit classes for minimum/maximum premiums at Yasiru

<i>Benefit class</i>	<i>Monthly premiums</i>	
	<i>Minimum</i> LKR 5–15	<i>Maximum</i> LKR 50–150
1 Death after the age of 18 and before 65 due to an accident	6 000	60 000
2 Permanent disability after three months before the age of 65 due to an accident	12 000	120 000
3 Death after the age of 18 and before 65 due to natural causes	3 000	30 000
4a Sudden death before reaching the age of 18	3 000	3 000
4b Sudden death between the age of 65 and 75	3 000	6 000
5a Hospitalization cost per day for a maximum of 15 days	30	300
5b Traditional or similar treatment cost per day for a maximum of 15 days	15	150

Note: Exchange rate is LKR 100 = US\$1

Source: Enarsson and Wirén, 2005.

Even though these group life products are voluntary, by distributing them through savings and credit organizations, the insurers and their delivery agents can streamline paperwork, minimize the number of transactions, and make the product more affordable for the low-income market. These voluntary products provide greater benefits to customers than coverage associated with loan protection, yet generally their market share is not particularly high (*see Table 15*). One explanation for the limited amount of sales is the fact that frontline staff are not sufficiently motivated, trained or rewarded to sell something that is not a core service. Another explanation is that the development of an insurance culture takes time: as people start to benefit from the coverage, others will start to be interested in it as well.

Table 15

Market coverage of selected voluntary life insurance products

<i>Microinsurance organization</i>	<i>Number of policyholders (voluntary life)</i>	<i>Potential size of the market</i>	<i>Market share (%)</i>
La Equidad and co-ops (Equidad)	18 223	218 000	8.7
La Equidad and WWF (Amparar)	11 150	44 000	25.3
Yasiru and NGOs	9 000	60 000	15.0
ALMAO and Sanasa	2 000	800 000	0.3
Columna and co-ops	54 000	500 000	10.8

Based on the lessons from several case studies, it is useful to consider the following features when implementing loan-linked voluntary term life insurance for the low-income market:

1. Demand is critical

If the product is designed together with the clients to make sure that the most needed coverage is included, then it will be more likely to succeed. The product has to be simple and easy to understand. Premium affordability, sum insured, and the number of dependants covered are all critical factors to ascertain from market research.

2. Distribution and premium collection

In microinsurance, the most common way of making term life available is by linking it to an MFI's loan term and using the loan as the mechanism for collecting premiums. Yet protection is only available for borrowers and often clients want insurance even when they are not borrowing. MFIs with savings services should link the continuation of life insurance to a savings account. Such MFIs should, of course, also market life insurance directly to members with savings accounts without waiting for them to take out a loan.

3. Make premiums affordable

The best way to make premiums affordable to the client is to collect them regularly. While frequent payments increase transaction costs for the MFI and the client, the burden can be reduced by using loans or savings accounts as conduits for premium collection.

4. Adverse selection

For voluntary life cover, a short waiting period can be introduced – typically one month – to control adverse selection. The waiting period can also discourage lapses as clients should be informed that if they miss a payment, they will be subject to the waiting period when they start paying premiums again.

The waiting period should be long enough to discourage those that seek to abuse the product, but short enough not to be seen as prohibitive.⁶ Strict age limits with reduced benefits may also be necessary to limit adverse selection in life insurance. The negative effect of early terminal illnesses, like AIDS, is difficult to control. The local knowledge present in MFIs' network is of vital importance for coping with this and other problems of adverse selection, which would otherwise threaten the viability of life insurance products. Adverse selection is also reduced by the fact that members have originally joined the organization to get savings and credit services, not insurance coverage.

5. Make it easy to make a claim

The best way to drive up administrative costs and ensure that clients are dissatisfied is to have an elaborate claims process. By making the products simple (e.g. if you are dead, then we pay) and reducing the scope of coverage (it is hard for a loan officer to assess whether someone is sick, but easy for them to see that someone is dead), costs will be lowered and satisfaction will be increased.

6. Avoid contestability for existing illnesses

Some insurers require that deaths arising from an existing illness are subject to a contestability period that can be up to a year. In reality, this stipulation is difficult to explain to clients and loan officers, and it can be difficult to implement because clients often do not have formal medical records.

7. Minimize the number of exclusions

A long list of exclusions is difficult (and time-consuming) for staff to explain and hard for clients to understand.

8. One price for all ages

It is standard practice for insurance companies to apply different rates for life insurance to people of different ages and sex. However, this can be difficult for staff and clients to understand. In cases when simplification is deemed necessary, a single rate can be introduced if benefits are small (at least until both clients and staff have increased their knowledge of insurance). The single rate means that young people are penalized, but the sums insured and

⁶ Not all experts agree that a waiting period is an appropriate way of controlling adverse selection risk. One month may not sufficiently control the problem, yet members usually pay for full coverage even though they do not receive protection during the waiting period. Alternative approaches are also discussed in Chapter 3.1.

premiums are so small that the differences are acceptable. For high value policies, a rating table will be necessary.

9. Simplified sales promotion

The basis for marketing insurance is a simple product that meets an obvious need. Promotion and sales staff need to be well trained in effective sales techniques. As discussed in Chapter 3.2, sales arguments should concentrate on the most important factors: what is the cost, what is the benefit and who is covered? In addition, there should be publicity in connection with benefit payments.

2 Savings-linked insurance

Banking regulations in most countries do not allow microfinance NGOs to offer savings facilities. However, during the last decade, some countries have developed separate legislation to regulate deposit-taking MFIs. In addition, savings and credit cooperatives, which constitute the majority of MFIs in some countries, are normally allowed to accept deposits from their members under cooperative regulations. For organizations that are allowed to accept deposits, savings-linked insurance has a huge advantage over credit-linked products because policyholders can have coverage without being in debt.

2.1 Life savings

The most common type of savings-linked insurance is **life savings**. The benefit paid from a life savings scheme is normally equal to the savings balance at the time of death of the insured. In the event of an accidental death it is common for multiples of the savings balance to be paid instead, such as three times the savings balance. In most cases, the insured appoints beneficiaries. The premium is normally deducted as a percentage of the insured's savings balance. This structure makes the product very cost-effective for MFIs.

A very efficient way of running a life savings scheme can be found in a savings and credit cooperative movement in Malawi, MUSCCO, where life savings insurance is an additional benefit for all members. This makes it possible for the participating cooperative societies to pay the premium on a collective basis. The society makes one payment for all members, calculated on the basis of total member savings at the time of payment. The monthly premium rate was recently increased from MK 2.50 to MK 4.00 per MK 1,000 sum assured per month, largely due to the effect of HIV/AIDS on mortality rates.

It is difficult to design a more cost-effective payment system than this. The great advantage is that all who have savings are insured and there is no risk of losing cover due to premiums being unpaid or in arrears. The risk of adverse selection is also minimal. Maximum coverage is MK 100,000 (US\$935).

However, life savings schemes do suffer from some shortcomings. It is common for people to reduce or terminate their savings during the difficult times before death (for example, to pay for healthcare costs or simply to compensate for loss of income). Hence, the savings balance is low at the time of death and the benefit likewise, providing limited value to the beneficiaries. It is possible to reduce this problem by basing the benefit on the average savings during, for instance, a six-month period one or two years before death. Such a method can only be recommended when old savings records are easily available and are preferably computerized. The method would require additional administration and actuarial expertise to make the necessary calculations, but would enhance the value of the cover.

If an MFI's members clearly demand life insurance, there are other solutions. A very effective way is to offer all members a fixed amount at the time of their death and to pay for the coverage once or twice a year as an administrative expense that is debited to the members' savings accounts. This means that insurance would be compulsory and that all members, or rather their beneficiaries, would get the same benefit. It would be more of a member-linked than a savings-linked insurance. The member's savings account would only be used to facilitate the administration of the service.

A similar scheme could, of course, be offered on a voluntary basis and with a (limited) choice of fixed benefits. This would increase adverse selection risks and administrative costs, but also be more adapted to individual members' demands. In computerized systems, costs may still be kept at a reasonable level.

2.2 Other savings-linked products

Besides life savings and the long-term savings and insurance products discussed in the previous chapter, there are other ways in which savings products can be used to extend insurance protection to low-income persons. Essentially, any type of insurance could be linked to savings with an account serving as a mechanism to minimize the transaction costs associated with premium collection. Opportunity International has started to experiment in Montenegro, Mozambique and Malawi with the savings account as a method of distribution. This arrangement allows the client to pay premiums incrementally over a month, with the savings account being debited at the month end.

VimoSEWA and SEWA Bank used the same approach several years ago, but it was not very successful because many account holders were not aware that the premiums were going to be deducted from their accounts. As discussed in more detail in Chapter 3.3, SEWA Bank now offers a fixed deposit account with the interest on the account being used to pay the premiums. As long as depositors leave their money in the account and the premiums do not increase, they will have permanent coverage (up to a maximum age) without ever having to withdraw cash for the payment, while retaining ownership of the principal in the savings account.

Another example is from Sri Lanka, where Yasiru provides insurance to poor people through community-based organizations (CBOs). Yasiru's system includes a "member's account" for each member. Out of the annual profit, 40 per cent is allocated to each member's personal account. The member can withdraw the money plus interest five years after termination of his/her membership. Unfortunately, in the present situation in Sri Lanka, where inflation exceeds the general savings interest level, including return on treasury bills, it is difficult to get real returns from members' funds. Still, the arrangement helps Yasiru's members to save some money for old age.

3 Product design and delivery issues

Based on these experiences, a number of issues, opportunities and limitations emerge relating to savings- and credit-linked insurance products.

3.1 Voluntary v. mandatory

A sensitive question for most MFIs is whether the service should be compulsory or voluntary. Mandatory coverage is by far the most cost-effective way to distribute insurance to the poor, and it protects far more people than if the insurance is marketed voluntarily. The risk of adverse selection is also minimized with compulsory coverage. Many microinsurance schemes suffer from a high drop-out rate, which over time will weaken people's trust in insurance and jeopardize the financial viability of services. With mandatory schemes, this risk is eliminated. Even with a reasonable drop-out level, the administration of a voluntary product may become so expensive that too small a portion of the premiums remains to pay benefits. Transaction and other costs will simply consume too much of the premiums and leave the clients with a poor return (benefits) on the fees they pay.

One way to overcome the limitations of mandatory coverage is through client education. Clients of MFIs generally know very little about insurance. Most microinsurance schemes face difficulties in reaching their target group

with marketing, education, training and awareness campaigns. Yet well-established MFIs have built-in channels for providing these types of services to members, which can also be used effectively for insurance purposes. Savings and credit cooperatives have a particular advantage in reducing the scepticism of compulsory services: their democratic structure allows all members to take part in a decision to provide mandatory insurance services.

An MFI's communication and training structure can also be used to involve clients in the design of insurance products, which can make mandatory cover more valuable or at least acceptable to the clients. If products have the type of benefits that the clients prefer, the viability of the insurance service also increases. As discussed further in Chapter 3.1, compulsory group insurance can be extremely useful as long as the clients are aware of what they are paying for and appreciate it.

3.2 Leveraging assets

Since MFIs are already involved in financial transactions with their clients, it is easy to add fee collection for insurance products. Some MFIs, however, have copied cumbersome and expensive procedures from the commercial insurance industry instead of developing insurance services based on their own specific advantages. For example, instead of using their MFI partners' savings and credit system for an integrated distribution of its products, Yasiru, in Sri Lanka, has recruited field agents to carry out marketing and collection of premiums.

All savings and credit cooperatives, and an increasing number of other MFIs, operate savings accounts. This provides for a very effective fee collection system. By means of direct debits authorized by the member, the premium is deducted from the account at specific intervals. Since most systems are computerized, this fee collection process is very cost-effective.

Microfinance institutions often have local knowledge about their customers that facilitates sales. It is easier to market something to a person you know, and easier for people to accept products promoted by known sources. Hence, the marketing, the premium collection and the claims procedure become more effective and efficient. When people know each other, it is difficult for clients to cheat. Consequently, in the microinsurance market, significant accommodations should be made in the normally required claims procedures to make them more appropriate for the poor (*see Chapter 3.4*).

3.3 Limitations

There are inherent limitations in loan protection and life savings schemes. Loan protection insurance, in some cases with a funeral aid rider, ends when the loan is repaid. Although this insurance has benefits for the client's family, it is still supply driven. Even when other benefits have been added to loan protection insurance, the benefits are only there as long as the loan is outstanding. There is no long-term reduction of risk for clients and their families. This limitation can be balanced by offering continuation policies or voluntary life coverage to people who stop borrowing.

Generally, it can be said that insurance services offered by MFIs tend to be standardized, compulsory and simple. These characteristics add to the cost-effectiveness of the products but, at the same time, the service is inflexible and may not meet the actual risk management needs of individual clients.

Life savings is a natural insurance service for savings and credit organizations. An obvious weakness of the product is that the balance in the account (and therefore, the benefit) is often lower just before someone dies, perhaps due to old age or a long illness. One way to overcome the problem is to relate the benefit to the average savings balance during a period prior to the occurrence of death.

There is a great risk that staff of savings and credit organizations will give priority to their core tasks and pay less attention to the insurance service. It may be necessary either to allocate insurance tasks to specific staff (if the insurance business can carry the cost of such staff) or to reward employees who work with insurance services. Although both measures will increase costs, they may be justified (*see Chapter 3.7*).

4 Conclusions

Savings- and credit-linked insurance products can make an important contribution to the protection of low-income people, and they can benefit the MFIs as well. To take advantage of this potential, MFIs should ensure that they fully exploit the systems they have established for clients' education, training and information provision to enhance the clients' awareness and ultimately develop an insurance culture. Client involvement in the development of products and their genuine knowledge about insurance are essential for successful operations.

For most savings and credit organizations, loan protection insurance is a natural starting point for the provision of insurance to the poor. Any additional insurance products or benefits should be simple, affordable and easy to

understand. It should be easy for members to continue paying premiums and get benefits even after their loans have been fully repaid.

A crucial requirement for the success of savings- and credit-linked insurance is for sufficient time and resources to be allocated to train the staff and management of the delivery agent (the MFI). If the MFI's personnel are involved in the development of the insurance service from the beginning, they are more likely to deliver the service properly. The question of appointing separate insurance staff and/or rewarding the MFI staff involved should be discussed and analysed at an early stage, preferably in dialogue with staff representatives.

Anyone involved in the introduction of insurance in an MFI should ensure that management is committed to the scheme, especially since savings and credit services are their core business and insurance is ancillary. It is important to find ways for insurance to complement and enhance the core business; otherwise it is unlikely to receive enough staff or management attention to succeed.

Savings and credit organizations should fully utilize their specific structure and capacity when introducing microinsurance. Instead of copying the expensive agent system used by the insurance industry, they should leverage their own systems for communicating with clients and for collection of loan repayments. All MFIs that operate savings accounts for their clients should use direct debits, allowing the organization to deduct premiums from clients' savings accounts at agreed intervals.

It is difficult to run simple microinsurance schemes profitably with low and affordable premiums for clients. Mandatory insurance reduces transaction and other costs substantially and is sometimes the only way to make a scheme viable. If a savings and credit organization plans to introduce compulsory insurance, it should involve the clients in the decision to do so. Cooperatives should use their democratic structure to get a formal approval by members before such measures are implemented.

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Although most low-income people working in the informal economy – men and women in paid or unpaid employment – generally face similar risks, their exposure to those risks and the impact of shocks differ due to their social, economic, cultural and political situation. For example, they differ according to their occupation (e.g. accident-prone construction workers), their place of residence (e.g. flood-prone areas) and other factors.

Men, women and children are exposed to different risks calling for different solutions. Therefore, microinsurance – as one possible solution – should be designed to address the specific needs of women (and men) and children (both girls and boys). In particular, more attention is required to integrate the practical needs of women and children (girls and boys) into product design and operations. However, gender equality cannot be attained solely by supporting microinsurance. Structural causes of gender discrimination, such as legal, social and economic policies, also have to be addressed to improve the strategic position of women.

This chapter begins by describing the specific risks to which women and children are vulnerable. It then illustrates how microinsurance can help address some of these risks. The final section explains that microinsurance alone will not be able to solve this problem, and for microinsurance to achieve its potential, significant social and policy changes are also required.

I Special risks affecting women and children (girls and boys)

Women are particularly vulnerable. Seventy per cent of the world's poor are female. Women and children face more violence, abuse and exploitation than men, such as forced prostitution, battery and extreme cruelty, or exploitative domestic servitude. Home-based women and child workers put in long hours but are paid only for a fraction of their time. In rural areas, cultivating family plots involves hours of backbreaking toil for no payment at all. In urban areas, they work long hours in unregulated, unhealthy and unsafe fac-

tories without the ability to protest or voice their opinions. Hence, there is a larger concentration of women and children at the lower end of the chain of equality and security in life.

This greater vulnerability contributes to stronger risk-averse behaviour. Women's tendency to be risk averse may be a rational response to their greater vulnerability and lack of control over their lives. This attitude, however, adversely influences the effectiveness of their risk-management strategies since risk-averse approaches tend to result in low returns, which make it harder to break the cycle of poverty.

While some risks can be addressed through appropriate microinsurance products, changes in the institutions involved (meso level), through organizational gender mainstreaming and gender accountability, are also required. Moreover, microinsurance can only make its maximum impact if improvements in the status of women in society and special protection for children – in particular girls – are achieved through macro-level policy interventions. Therefore, this section distinguishes between the risks affecting women and children that can be managed through microinsurance and those that require state intervention and a general gender-reorientation in society at the macro level. A combination of the two strategies, complementary to each other, is addressed in this chapter. However, the emphasis is placed on the risks and mechanisms that can be improved through microinsurance.

1.1 Risks that can be (partly) managed through microinsurance

Compared to other poverty-alleviation programmes, microinsurance is relatively new and the demand for it needs to be further explored. However, experience has revealed the need for customized microinsurance products, addressing the practical needs of women and children (girls and boys). This section considers the health, property and life-cycle risks for women and children that could be addressed by microinsurance.

Health risks

- Women are vulnerable to specific health risks including high maternal mortality and complications surrounding pregnancy and childbirth. An estimated 300 million women suffer from permanent damage to their health due to pregnancy and childbirth (Tuladhar, 2003).
- Women are more susceptible to some illnesses, such as sexually transmitted diseases (including HIV/AIDS) than their male counterparts. The risk for women is greater in societies where male promiscuity is prevalent.
- Children's higher susceptibility to diseases and accidents inherently puts them at a higher risk for illness. In addition, since crèches are not available,

many mothers take their children with them to work, exposing them to workplace accidents.

- The ILO estimates that 218 million children are engaged as child labourers in the world today. Nearly 58 per cent of these children work in hazardous conditions found, for example, in mines and the chemicals and pesticide industries, and with dangerous machinery. Many are less than 10 years old and their physical immaturity leaves them more vulnerable to work-related accidents and illnesses (ILO, 2006).
- Health risks are also related to hazardous working conditions. These risks arise from environments such as work in leather tanneries, which can cause exposure to toxic pesticides and other chemicals; work in the carpet and recycling industries and street trading, which can cause severe respiration problems; and work on construction sites, which is especially prone to accidents.
- Household work has an adverse effect on the health status of women and girls. Carrying heavy loads such as firewood may damage girls' health by causing conditions such as chronic back pain. Fetching water and daily contact with water (e.g. washing clothes) in tropical regions increase exposure to waterborne diseases such as malaria and schistosomiasis. Other household work, such as cooking with firewood or charcoal, may lead to respiratory problems and burns.
- Traditionally, women are the care-providers for children, the sick and the elderly. For female-headed households, this can have serious economic consequences because of the time women have to spend away from income-generating activities to provide care.

Property risks

- Women can be extremely vulnerable in cases of divorce or widowhood owing to unequal control of assets. Even if women are paying for asset insurance, they may not benefit from the protection if the asset does not belong to them.
- Due to their low income, women are less likely to invest in improved business tools or disease-resistant livestock and crops, or to be able to afford veterinary care or other preventive measures.
- Physical vulnerability puts women's property at risk to theft and crime. Harassment by local authorities such as confiscation of property and destruction of market stalls affects women more than men, especially where households are headed by a female (Mayoux, 2005).
- Poor women often reside and work in higher-risk areas, which makes their assets more susceptible to damage or destruction (e.g. congested living conditions are prone to fire). The situation escalates as women have little or no money to respond to covariant shocks.

Life-cycle risks

- Women are especially vulnerable to the death of their husband because they often lose their property to other relatives. In the event of their own death, women fear that their spouse may use an insurance payout intended for the children's education to invest in a new wife or for other undesirable purposes.
- Since most women work in the informal economy, they lack protection in old age. Raising children without any maternity benefits leads to part-time work with low income. Thus, even if poor women were in a position to save, it would be insufficient to provide for their retirement needs. With the breakdown of traditional families, other forms of old-age protection become even more important.
- Lower education forces women to take up unskilled labour and increases their likelihood of being unemployed.

1.2 Risks due to gender discrimination that cannot be managed through microinsurance

In most cases, microinsurance can only address the symptoms of these risks, such as providing treatment to those who are ill, but it cannot solve the root causes, i.e. the reason why they were ill in the first place. For microinsurance to be effective, there is a need for strategic changes towards gender equality in society. Indeed, as practical needs and strategic interests are interrelated, these approaches – microinsurance and a broader strategy for gender equality – complement each other.

In most developing countries, women are marginalized. The low social status of women (and girls), and harmful traditional practices (female genital mutilation, dowry murder, honour killings and early marriage) in some societies have adverse affects: non-nutritious diet increases proneness to ill health, and lower priority in getting medical treatment results in poor health.

In their childhood, girls are more likely to receive little or no education and less food than boys. Malnutrition has a chain reaction. It not only weakens children physically, it also impairs their ability to learn. Children who cannot complete primary school are less likely to have the literacy, numeracy and other skills required for a well-paid job in adulthood. Children orphaned or displaced through HIV/AIDS, armed conflicts, riots and civil disturbances are also at risk of missing out on school and the protection of a family.

As adults, they work in laborious yet low-paid jobs. Women workers are over-represented in the informal economy, with no social protection, low wages and high male-female wage differentials even for illiterate workers. Women have less secure work in the informal sector and are displaced sooner when work becomes more skilled and when technical qualifications are needed.

Technological change has deprived women of traditional livelihoods (e.g. power-loom technology). Since women are usually less educated, they are most affected by this development and entry to more specialized and skilled industrial work is extremely difficult. These problems become more severe as the informal economy expands. Informal women workers are the most ignored in terms of hazardous working conditions, deprivation of maternity benefits and loss of employment during pregnancy.

Women also face domestic violence and abuse. According to the Inter-American Development Bank, domestic violence alone causes tremendous costs for care and rehabilitation. Women who are victims of violence suffer from serious health problems (IADB, 1999). Apart from the suffering inflicted on the women, violence against women and girls occurs on a scale that places a heavy long-term burden on public health systems (UNICEF, 2000).

2 Microinsurance to address the special needs of women and children

Microinsurance was primarily initiated by microfinance institutions that wanted to secure their loan portfolios and lessen the burden of outstanding loan repayments for the family of the deceased member. Some organizations are also keen to provide health microinsurance owing to the lack of affordable and quality healthcare. For example, many groups started community-based health schemes, especially in Africa (see Chapter 4.3). As these activities were typically initiated by organizations involved in poverty alleviation and women's empowerment, microinsurance was intended to benefit women (and their families).

An analysis of current microinsurance experiences reveals that some progress is being made to reduce the vulnerability of women and children, but several challenges still have to be addressed. This section considers the experiences of microinsurers in meeting the needs of women and children, and identifies where future improvements might be warranted.

2.1 Product development

It is striking that only a few microinsurers distinguish between the special needs and opportunities of women and men. Most organizations refer to "households" or "policyholders" and thus do not explicitly reflect a gender perspective. Many microinsurers serve large numbers of women, so they assume that women are benefiting. In practice, however, microinsurance products are not always designed to address the unique needs of women (or children).

To address this issue, before starting microinsurance, gender-specific demand studies are needed to reveal the specific needs of the target market, including the situation of children (separately for girls and boys). As microinsurance is only one risk-management tool, the existing gender-specific risk-management strategies should be analysed – microinsurance cannot, and should not, solve all risk-related problems.

Once microinsurance is implemented, systematic customer satisfaction assessments are an important source of information to check the ongoing appropriateness of its products and operations, as well as its risk-management effectiveness. Furthermore, the involvement of the target group in the governance and management (e.g. client advisory committees) can help ensure that women's voices are heard when shaping the design and direction of the scheme.

2.2

Benefits

In designing **health schemes**, microinsurers need to ensure that they cover women's health concerns, especially those related to pregnancy, delivery and maternity, gynaecological diseases and HIV/AIDS. For example, in Benin AssEF's benefits largely focus on women's needs, with a special emphasis on reproductive health (gynaecology and obstetrics). In India, Karuna Trust's insurance product covers any admission to a public hospital, so that child delivery, caesarean section and other needs of women are covered.

Some schemes, however, shy away from offering maternity benefits because, unlike in the case of illness or accidents, women have (some) control over whether or not they get pregnant. Consequently, pregnancy is not a risk that can be risk-pooled in a pure insurance sense. Furthermore, there is a significant adverse selection risk of women who know they are pregnant (but not yet showing) who then enrol in an insurance scheme.

When Shepherd, an Indian NGO, was negotiating its UniMicro Hospitalization scheme with the state-owned insurer UIIC, if it had included child delivery in the policy, the price would have been roughly double *and* there would be a nine-month waiting period. Consequently, Shepherd's members chose not to include it because of the extra cost and because it would only benefit some members. Instead, Shepherd helps its clients cope with maternity expenses through a soft loan scheme (*see Box 23*). This suggests that if organizations cannot include women-specific risks in an insurance policy, they should consider offering alternative risk-management tools.

Box 23

Shepherd's Sugam Fund

The Sugam Fund is designed to assist pregnant women members of Shepherd. Capitalized by contributions from members along with a matching grant from Friends of Women's World Banking (FWWB), members can take a soft loan of Rs. 2,000 (US\$44) to 3,000 (US\$55) from the fund. The money is kept at the block-level federation so it can be easily accessible; the leadership of the SHGs is responsible for managing the fund. With every premium paid by the member, a Rs. 5 (US\$0.11) contribution is made towards this fund so that it increases in value. The fund can also be utilized to provide support to adolescent girls.

Adapted from Roth et al., 2005.

It is also important to design benefits to accommodate children's health-care needs. Health insurance for the entire family benefits girls and may convince husbands to spend money on them, which may be quite relevant if women have limited negotiating power.

For example, ServiPerú's *Previsión Familiar* or Family Plan for up to five persons covers medical consultations, diagnosis examinations, medical emergency services, medical care as a result of accident, hospitalization as a result of illness or accident, and funeral services. Health services are provided at its own medical centre, which offers services for women and men of all age groups. It provides paediatric services for children and there is a gynaecological and obstetrical clinic for women. In addition, the centre runs the following special programmes/clinics:

- Child care programme
- Women care programme
- Care programme for the elderly
- Family planning
- Preventive medicine

Life insurance policies can also take into account the special needs of women and children. ALMAO in Sri Lanka has decided to do this directly by creating "Senehasa" a children's policy. The plan pays benefits to the children of the insured if the parent dies during the term of the policy. What is unique about this policy is that, instead of providing a lump-sum payment, 20 per cent of the sum insured is payable on death and thereafter 20 per cent of the sum insured is paid on each subsequent anniversary of death for four years. This gradual payment of benefits suits the needs of child-

beneficiaries as it provides them with some ongoing financial support as they grow older.

La Equidad has taken a similar approach to staggering benefits over time. In Colombia, when a breadwinner in a poor family dies, one of the key coping mechanisms is to take children out of school. Equidad's *Amparar* product tries to prevent that eventuality by paying a monthly education benefit for up to 24 months. The family also benefits from a monthly cheque to buy groceries for one year.

Delta Life in Bangladesh has developed a daughter's marriage endowment policy designed as a savings scheme to benefit the policyholder's daughter when she turns 18. Although it is marketed as a marriage product, it could be used for education or other purposes. The term can be between five and 16 years depending on the age of the daughter (who must be between two and 13 when the policy commences). If the parent-policyholder dies during the term, then the daughter-beneficiary will receive the full sum insured when she turns 18 (assuming that the premiums were up to date). The timing of the maturity is an intentional effort to provide an incentive for parents to wait until the girl is at least 18 to marry.

This endowment policy was not Delta's first attempt to address the needs of daughters. In the mid-1990s, it experimented with female child education and offered an insurance product that would pay bonuses when the policyholder's daughter passed certain education milestones, but a penalty would be charged if the daughter married before a certain age. In collaboration with the government, Delta also offered a family planning and insurance product that paid higher sums insured to policyholders who had fewer children. Although the product was phased out after the government changed its policy, it is an example of the social engineering that could be associated with insurance for the poor.

2.3 Other product design features

Besides the benefit package, it is also important to take into consideration the effects of other product design features on women.

Premium payment: As low-income women are predominantly casual and seasonal workers, regular monthly premium payments can be difficult to pay, but an annual payment may not be suitable either. Flexible arrangements are most appropriate. However, they have to consider the administrative capacity of the microinsurance organization and the transaction costs. Owing to the irregular and low income of women, microinsurers should offer a range of premium payment options, e.g. a grace period of several months and a

flexible payment schedule that allows for payment of small amounts according to the particular financial situation of women. This applies particularly to endowment products as the policy's value is significantly reduced if premiums are delayed (*see Chapter 2.2*).

Price: There is often a conflict between the desire to offer affordable products for the poor and the desire to become financially viable. This dilemma has sometimes resulted in a focus on higher-income clients and excluded poor women. Charging the poor lower premiums could help avoid some negative implications, especially for women since they typically earn less than men. For example, Grameen Kalyan and BRAC's Mhib in Bangladesh charge a lower premium to the microfinance clients of their respective sister companies, who are almost all women, than to the general public.

Another approach would be to use the price as a way of creating incentives or encouraging certain behaviour. For example, India's VimoSEWA offers a Rs. 20 (US\$0.45) discount to members who enrol their whole families (*see Table 16*). Other objectives such as the promotion of small families (reproductive health programmes) could be pursued by charging lower premiums for smaller families.

Table 16

VimoSEWA's coverage and price in rupees

<i>Scheme 1</i>	<i>Member</i>	<i>Spouse</i>	<i>Children</i>	<i>Family</i>
Natural death	5 000	5 000		
Hospitalization	2 000	2 000	2 000	
Asset loss or damage	10 000			
Accidental death	40 000	25 000		
Spouse accidental death	15 000			
Premium: Annual premium*	100	70	100	250

<i>Scheme 2</i>	<i>Member</i>	<i>Spouse</i>	<i>Children</i>	<i>Family</i>
Natural death	20 000	20 000		
Hospitalization	6 000	6 000	2 000	
Asset loss or damage	20 000			
Accidental death	65 000	50 000		
Spouse accidental death	15 000			
Premium: Annual premium*	225	175	100	480

* VimoSEWA also has another premium payment method – the fixed deposit account – which is described in Chapter 3.3, but family coverage is not available through that payment method.

Note: Rs. 44 = US\$1

Exclusions: Many of the gender-insensitive aspects of insurance policies may be tucked away in the fine print. For example, because of the high risk of

death during childbirth, Delta Life excludes women in their first pregnancy from taking out a policy. For many insurance products, age limits restrict protection for small children and the elderly, who need protection the most. Ideally, microinsurers should find ways of making their products more inclusive.

Claims settlement: Complicated documentation makes claims settlement more difficult. As women are less familiar with official written procedures, incomplete documentation may lead to rejection of claims. If combined with a low social status and little negotiating power (e.g. with officials), it may be difficult to obtain the necessary documents.

Agent commission: Commissions for renewals are much lower than for new policies. Experience reveals that illiterate people – who are predominantly women – do not remember the expiry date of their microinsurance contract and thus do not renew their policies, but often believe that they are still insured. If the agents receive a higher commission for new contracts, they will prioritize selling new policies rather than following up on renewals – at the expense of less-educated women.

2.4

Distribution

As described in Chapter 4.7, there are limitations on the reliance on MFIs as a distribution channel for microinsurance. For example, a lack of transparency has been documented if microinsurance is linked to loans; microcredit borrowers in Zambia (Manje, 2005) and Uganda (McCord et al., 2005a) were not aware of the fees charged for loan processing and the microinsurance premium payment (sometimes women were not even aware of their insurance coverage). The deduction of premiums from the loan amounts along with other loan fees has resulted in a perception by clients that insurance is a part of the cost of acquiring a loan. Although these limitations apply to all clients, women may be more affected as they are less familiar with contracts and earn less money.

Cooperatives are also common vehicles for the distribution of microinsurance. However, often the member of the organization is a man. For example, at Columna in Guatemala, the spouses of credit union members are allowed to purchase the Special Life Plan without having to join the cooperative, but very few women actually purchase the insurance. Similar findings come from the credit unions associated with TUW SKOK (Poland) and La Equidad,¹ and the cooperatives associated with Yeshasvini (*see Box 24*).

¹ La Equidad has overcome this distribution bias by also collaborating with a microfinance institution, Women's World Foundation, which serves primarily women.

Box 24

Outreach at Yeshasvini

Although some 78 per cent of the adult population in Karnataka, India is in some way connected to a cooperative society, most cooperative members are men. Yeshasvini Trust covers the members of the cooperative societies and is open to their families as well. Yet only 40 per cent of Yeshasvini's insured members are female. As the women themselves are not usually members of the cooperatives, it appears to be more difficult for them to obtain insurance from Yeshasvini: the member is the first one to enter the scheme and coverage of the family may come later. Changing this, perhaps by introducing a reduced fee when the whole household is covered, could increase women's access to insurance and reduce adverse selection at the same time.

Adapted from Radermacher et al., 2005b.

As a result, these are not particularly effective distribution channels for reaching women. VimoSEWA has adopted the opposite approach whereby access to the benefits is through women. A female client can decide whether she also wants to add her husband and children. She would not be able to choose coverage for herself and her child if she has a husband; she would not be able to cover her husband and not herself – the priority is to cover women as SEWA is a women's organization.

“Women-friendly” delivery channels require direct and regular contact with the female clients through trustworthy, familiar people such as the field staff of NGOs/MFIs, committed healthcare personnel, and female insurance agents to reduce the likelihood of misleading selling practices and confusion about insurance contracts. Marketing strategies should also include a strong educational element since a lack of proper understanding of insurance and complicated insurance policies can lead to denial of services as less-educated women cannot (adequately) submit their claims. Lack of comprehension, and the related risk of becoming a victim of fraudulent behaviour, might be more relevant for women than for men.

For example, the door-to-door collection of premium payments by Delta's field officers and India's Tata-AIG's agents generates access to these products for women who for various reasons cannot leave their homes. The fact that the majority of the organizers are women also means that the distribution channel is more approachable by and accessible to women. Indeed, Tata-AIG's agents are almost all women and they focus first on selling to people that they already know.

2.5 Target groups and policyholders

One of the great ironies with many of the microfinance-linked insurance schemes is that they often cover the life of the borrower, who usually is a woman. As a result, for a woman to “benefit” from insurance, she would have to die first. For example, in the Philippines, CARD’s initial insurance scheme simply covered the members in the event of death. The organization realized through discussions with members and staff that the insurance cover provided little benefit to the women themselves. This realization was an important input in the decision-making process that resulted in additional cover for the spouse and children, which were more valuable benefits for CARD’s women members.

Several other MFIs, including ASA, SPANDANA and FINCA Uganda, have gone through this same evolution. Indeed, a priority need for women is **life insurance for their husbands**. If their husbands die, that is when they really need insurance benefits. Microfinance institutions that have introduced spousal coverage also recognize that the MFI benefits as well, since the woman borrower would have much greater difficulty repaying her loan if she did not have insurance on her husband’s life.

When schemes allow persons to choose who will and will not be covered, often women and girls are not enrolled because their lives or their health is valued less by the household decision-makers. **Family coverage**, like ServiPerú’s Family Plan or UMSFG’s health insurance (*see Box 25*), is a way of overcoming the problem caused by the ability to select family members for cover and it helps to control adverse selection risk. TUW SKOK’s “My Family”, an accidental death and disability product, covers the credit union member, his or her spouse and children, and parents of adults up to 65 years of age. Similarly, when VimoSEWA included children in its hospitalization benefit package, it realized that it needed to cover all of the children in the household for one price so that parents would not be forced to choose which child to cover.

Box 25

Family coverage at UMSFG

At UMSFG in Guinea, membership in an MHO is family-based. All dependants must be registered. Group leaders are responsible for ensuring that no household members (particularly children) are excluded from coverage. To ease their task, MHOs offer free coverage for children born during the budget year. In polygamous households, which are numerous in some areas, family registration is carried out separately for each spouse and her dependants. One membership card is issued for each mother and her children.

Adapted from Gautier et al., 2005.

If a woman has life insurance coverage, she should be able to choose who the **beneficiary** is. When given the choice, many women nominate their daughters, so the benefit could be used for their education. If the children are minors and the woman does not trust her husband to use the benefit according to her wishes, then she should be able to name a guardian whom she trusts.

3 Policy tasks to improve the strategic situation of women and children

Considering the needs and the current experiences with microinsurance, a number of measures are required for providing more comprehensive protection to women and children – with the emphasis on girls. Several practical needs of women, girls and boys can be taken up through improved microinsurance product design at the micro level, and operations at the meso level, while other strategic interests require long-term changes in the labour policy and the status of women in the society (macro level).

Since this book's focus is on microinsurance, policies for improving the strategic situation of women and children are only discussed briefly, as they are beyond the scope of microinsurance alone to implement. Nevertheless, they are essential for strengthening the impact of microinsurance and advancing towards the goal of gender equality.

State responsibility for social protection: However successful microinsurance might be, it will never be in a position to provide substantial protection, as discussed in Chapter 1.3. Private mechanisms have a supplementary role – comprehensive social protection is the responsibility of the state. Recognizing this responsibility, the state-run microinsurance schemes in Peru (SMI), Bolivia (SMS) and Paraguay (SI) all started by focusing on the most important epidemiological needs of maternity and early childhood diseases – risks that private insurers, even microinsurers, are less likely to address.

Similarly, the state has an important role to play in protecting vulnerable groups against covariant risks, which microinsurers cannot easily address since it is often difficult or not cost-effective for them to access reinsurance. For poor families, and women in particular, ex post coping strategies are not sufficient to cover losses resulting from catastrophic events – they require assistance from the state.

Thus, lobbying and advocacy work by civil society organizations is an important means for providing comprehensive risk coverage. This must be approached with some caution, however, since the increased supply of microinsurance should not be a justification for a decreasing role of the government in the provision of social protection.

Community-based risk pooling mechanisms are particularly vulnerable because of their limited financial resources. Catastrophic losses, repeated idiosyncratic risks and poor controls may deplete their resource pools and lead to their collapse. UMASIDA in Tanzania had to suspend operations after only six months, and then restart several months later when it had restructured its controls (McCord, 2000). When schemes fail, poor women who do not have access to any microinsurance are likely to suffer more than men because of their lower earning capacity and limited assets.

Legal and regulatory issues: Formal and informal laws determine issues related to inheritance, marriage, rights over assets, income and labour utilization – and thus have an impact on women’s bargaining power over scarce resources at home and in society. In this context, formalizing working conditions and ensuring equal property rights are important steps towards improved protection and the social status of women.

Formalizing contractual arrangements in the informal economy and encouraging employers to pay for social security would benefit women in particular. Creating a suitable regulatory environment that promotes the formalization of informal work would enable low-income market women to access appropriate benefits. This includes the official recognition of civil society as an essential promoter of microinsurance and suggests that there should be financial compensation for their services (e.g. commissions paid by insurance providers or administration fees paid by government institutions).

Signing conventions on child labour and human rights and strengthening the enforcement of these laws are also essential for the protection of children.

Improvement of existing services: Women’s participation in the monitoring, management and planning of government programmes such as healthcare centres and rehabilitation programmes for catastrophic events will increase the likelihood that these services will meet the needs of women.

Economic reforms: Even if new technologies are introduced, which, in principle, could increase productivity and enhance the wealth of men and women, women might be worse off after such innovations. As women have less access to education and vocational training than men, they are displaced more easily from traditional jobs. A consequence for policymakers is that whenever technological changes occur, intervention may be necessary to make sure that the status of women is not undermined. Such intervention might include affirmative action creating new opportunities, skill training and quality employment for women.

4

Conclusions

Owing to a number of factors, including social, economic and political conditions, women, men and children are exposed to different types of risk. Furthermore, the same risks can affect them differently. Their behaviour towards risk management and their access to risk-management strategies may also differ.

The notion that NGOs and MFIs are working towards the empowerment of women and thus automatically consider the gender perspective in their microinsurance operations has proved to be wrong. Greater attention to gender-specific needs is required. Shortcomings are exposed when the “household” or the “family” is considered as a (homogeneous) unit for risk-management strategies. Rather, emphasis needs to focus on gender-specific risk-management instruments.

Gender differences can significantly affect the design of an insurance product. Experience has revealed the need for customized products reflecting the needs of women and children, particularly girls. Even if products are jointly developed with female clients, their needs are not necessarily addressed; insurance providers often exclude benefits such as gynaecological diseases and treatment related to pregnancy. Even if microinsurers exercise their negotiation power, there are limits to what low-income groups can pay in relation to what an insurance provider may include in the benefit package. In these cases, other risk-management instruments such as preventive measures or microfinance can complement microinsurance products. Furthermore, private microinsurance should be seen as complementary to the social protection responsibilities of the state.

Women on average are subject to greater vulnerability than men since they work predominantly in the informal economy, without any social protection. They earn less than men on average, have little ownership of and control over assets, are more likely to care for children and elderly, are more likely to live in poverty, and are less likely to have health insurance and pension coverage. These conditions, combined with a low status in society, cannot be solved through microinsurance, but need long-term policy intervention at the macro level. If these circumstances are changed in favour of women (and other discriminated groups such as children), their protection will be enhanced and microinsurance can live up to its full potential.

3 Microinsurance operations

3.1 Product design and insurance risk management

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Product design for microinsurance follows the same basic rules as conventional insurance: the insurer needs to establish demand from the market for insurance, determine the risks that can be insured, and devise insurance risk-management processes for ensuring the product's viability.

The design of microinsurance products, however, has some unique complications. Particular challenges are the small premiums and benefits driven by the market's limited resources and extreme cash-flow constraints, which restrict the scope of underwriting, claims management and product complexity. These challenges require scale, innovation, efficiency, simplicity and intelligent risk management.

Moreover, some microinsurers have a more complex mandate than insurance companies. The financial and economic drivers of sound insurance business may be supplemented by a development agenda, for example to expand access as widely as possible or to ensure inclusion of certain risks that might be commercially excluded. Not all microinsurers are subject to these influences, but where they are, it is critical that sound risk-management principles are not sacrificed. Where "non-commercial" risk is taken, it must be understood and managed.

As explained in Chapter 1.2, there is no "one size fits all" solution. Customer needs, preferences, appropriate delivery mechanisms and regulatory requirements vary tremendously from one territory to the next. Deep knowledge of local conditions is a prerequisite for designing successful microinsurance products.

This overview of product design answers the following questions:

- What are the needs and demands of the target market?
- Who is eligible for microinsurance?

¹ References in this chapter to RIMANSI and market research in the Philippines, Dong Trieu (Viet Nam), African Life (South Africa) and Constanta Foundation (Georgia) are drawn from the authors' experiences, not from the case studies.

- What are the terms of cover and the premium payment options?
- What are the benefits?
- How does product design provide for control of insurance risks?

I Market research

I.1 Initial market research

The product design process begins with market research, which involves four basic steps.

a) Define the target market

Some organizations, like microfinance institutions, may determine that the insurance market is the same as their existing savings and credit markets. Others may introduce insurance to gain access to new markets – for example, persons who are not interested in borrowing, but do want insurance. A key decision is whether the microinsurer will just target the most vulnerable or whether it wants to service the broader low-income community with a range of product options. For example, the health insurance schemes of BRAC and Grameen Kaylan in Bangladesh do not just serve the members of their corresponding MFIs, but the community in general, charging higher premiums to non-members as part of the organizations' sustainability strategy.

b) Identify what risks they face and need to insure (and which risks are insurable)

Demand research will help identify the most appropriate insurable events to cover: What risks are target groups most worried about, or least able to cope with through informal mechanisms? As illustrated in Chapter 1.2, low-income persons typically worry about the premature death of breadwinners and their own sickness and that of their family members. Often the poor have some coping mechanisms at the community and/or household level through savings, borrowing and reciprocation. Insurance should complement these existing mechanisms.

c) Determine which product features are important to the target market

The third step is to assess the needs and demands of the target market, and to get information on product-specific details, such as the levels of coverage (e.g. sums insured) and types of benefits (e.g. inpatient, outpatient and pharmaceuticals) which are most important to them. For example, for life insurance, would they want pure insurance cover (e.g. term life) or insurance with a savings component (e.g. endowment)? Are they interested in covering just

themselves, or would they prefer to include their spouses, or their whole families? How quickly would they need, want or expect to receive claims payments? Where can policyholders make premium payments or submit claims?

d) Establish how much potential policyholders are willing and able to pay

Lastly, it is necessary to determine what the target market is willing to pay for these services. Demand can vary tremendously, even within the same country. Two surveys of microfinance clients in the Philippines came up with very different results. The borrowers from an MFI in central Luzon wanted at least Php120,000 (US\$2,160) life insurance coverage for themselves and Php 60,000 (US\$1,080) for their spouses and children, and they were willing to pay for it, having been conditioned to paying premiums to the MFI's previous insurance programme. A sample of similar clients of an MFI in northern Mindanao indicated that they could at most afford premiums providing Php 30,000 (US\$540) of coverage for themselves, Php 10,000 (US\$180) for their spouse, and Php 5,000 (US\$90) for death of a child.²

It is useful to investigate affordability and product design preferences in concert with each other. Everyone might like to have claims paid immediately, or to cover their whole family, but how much are they willing to pay for those features? Given the cost constraints facing the target market, an explicit link between product design and financial consequences helps clients make appropriate value-driven decisions, while securing their buy-in to the scheme. An example of this type of process has been developed under the Social Re programme to enable sensible decisions to be made around benefit package design (Dror and Prekker, 2002).

When assessing willingness to pay, through focus groups or individual interviews, prospective customers may overestimate their capacity to pay, which could lead to subsequent dropouts. Information about the level of income is another, perhaps more reliable, means of assessing the payment capacity of the target population. For example, when comparing the annual income with the actual contribution paid to micro health insurance schemes, CIDR found out that poor households in western Africa do not allocate more than 2 per cent of their income (Galland, 2005a). In addition, when designing a product for the poor, it has also to be taken into account that income may change from one year to another. A product that is affordable one year may not be affordable the following year.

² Research conducted by RIMANSI (Risk Management Solutions, Inc.), a microinsurance resource centre based in the Philippines.

1.2 Ongoing market research

Market research must not fall by the wayside once a product is launched. Insurers should maintain contact with their clients periodically to ensure that the services are still relevant and valued by customers.

The very high lapse rates experienced by some microinsurers may be a consequence of failing to keep an ear to the ground: problematic elements of product design should be identified and, where possible, rectified to ensure ongoing viability. Policy renewals or persistency and new business rates jointly provide feedback about the value perceived by clients, and should be carefully monitored. Qualitative research such as focus group discussions may also provide further insight into the mechanics of the market and customers' preferences and dissatisfactions.

1.3 Consumer education

The target market's exposure to or familiarity with insurance must be assessed. As discussed in Chapter 3.2, if the market does not understand insurance, or does not trust it, then client education needs to be built into the marketing and product delivery. Insight into the preferences and concerns of existing policyholders will also help the insurer design appropriate financial education to manage policyholder expectations.

1.4 The competition

To date, many microinsurance initiatives have been the first movers in the local market, trailblazers entering virgin territory without competition. As time goes by, this is likely to change, as competitors enter the market with better products. Consequently, it is important to gather market intelligence on what competitors offer and the perceptions of their value in the market when considering a new product.

There can be an advantage in being a "smart follower", learning from the mistakes of those who have gone before. The Ugandan MFIs that collaborated with AIG in 2000–2002 rode on the coat tails of FINCA Uganda, which was the trailblazer in learning about insurance and the low-income market. The costs of introducing insurance in those organizations were significantly lower than in FINCA.

2 Eligibility

Who should be eligible for coverage? This difficult question must be considered in the context of the microinsurer's objectives and the membership's preferences, but with an acute awareness of the risk-pooling principles that apply. For microinsurance, the goal is to strike a balance between broad inclusion, sufficient benefits, low premium rates and sustainability. Eligibility considerations may be driven purely by economic circumstances since large volumes of clients with small premium amounts require minimal underwriting work, permitting broad inclusion. There may also be social objectives that require broader inclusion.

When determining eligibility, it is necessary to consider whether the product is designed for groups or individuals, whether it should be mandatory or voluntary and what approach the insurer wishes to adopt to covering higher-risk persons.

2.1 Group insurance

The primary feature distinguishing commercial group insurance from individual insurance is that many people are insured under one master policy. The group policyholder decides what type of coverage to buy for the members of the group. The policyholder is responsible for enrolling members, collecting premiums, disseminating certificates of insurance and product information, and helping members file claims. The policy describes and defines the eligible members of the group.

Underwriting guidelines for group insurance generally begin by specifying the fundamental requirements that define a group. The main criterion is that the group must have been formed for reasons other than to obtain insurance. For example, if a utility company required the household to be insured as a condition of being connected to the power grid, then the group is clearly defined and insurance coverage is required by virtue of being connected to the grid. It is quite unlikely that a family would seek to acquire an electricity connection to gain access to insurance. This mechanism limits the scope for adverse selection and allows more relaxed underwriting and risk management. Examples of groups targeted by insurers include employees in a company, labour union members, and affinity groups such as professional associations.

Mandatory group insurance is probably the most common type of microinsurance. For example, the microinsurance programmes spawned by many MFIs are similar to the membership of the CARD MBA in the Philippines, which is composed entirely of CARD's borrowers. The membership

of CARD MBA is a very low-risk group. There is minimal adverse selection due to mandatory participation; the participants are all women aged 16 to 64 and are actively engaged in their respective livelihoods (for which they are borrowing from the MFI); the group is thus relatively homogenous and in good average health. To minimize risk, even the 30,000 savers of CARD Bank cannot participate in the MBA because elective coverage would raise claims costs, while mandatory coverage would be difficult to sell to savers.

To be demand-driven and client-focused, one would expect that voluntary coverage would be the most appropriate. Yet in the field of insurance – and microinsurance in particular, where affordability is so important – a strong case can be made for compulsory coverage. Mandatory insurance:

- reduces costs due to higher volumes and lower collection and underwriting costs;
- lowers risk because of the broader base and limited adverse selection;
- improves claims ratios because it brings in the lower risk individuals (positive selection) who would otherwise opt out or wait to get coverage when they are older;
- reduces vulnerability to staff fraud since it reduces the chance that agents could sell policies and pocket the premiums.

One of the biggest disadvantages of mandatory coverage, besides the fact that people are required to buy something that they may not want, is that the distribution system tends to overlook the consumers' need for information. This comes through very clearly from the research in Uganda where many clients have a significant misunderstanding of what the coverage entails, which has led to profound dissatisfaction (McCord et al., 2005a). As discussed in the next chapter, when offering mandatory coverage, microinsurers (or their agents) need to constantly promote the good value of the programme. Clients need to be constantly educated about the benefits of buying an intangible service, i.e. security and peace of mind.

2.2 Voluntary group insurance

Group insurance can be offered on a voluntary basis in two different ways. Either members of the group are covered unless they specifically decline coverage or each member of the group must choose to enrol in the scheme. The costs and risks associated with the first option are often closer to mandatory coverage, whereas the second option is more akin to individual insurance, with greater concern for adverse selection. Sometimes there are grey areas between group and individual coverage. For example, both VimoSEWA

(India) and ServiPerú have group policies from insurance companies, but they are marketed and sold individually.

If potential insureds are not already in groups, then one strategy employed by some microinsurers is to create groups. This is the approach taken by the *mutuelles de santé*, such as UMSGF (Guinea), whereby rural communities are organized into groups, and the groups formed into mutuals, and the mutuals affiliated into federations. To overcome the adverse selection risk that comes with groups created for insurance purposes, UMSGF encourages all members of the community to enrol and membership is often on a family basis.

Microinsurance providers can combine the advantages of mandatory and voluntary group coverage in several ways. One way is to make insurance mandatory for all members of an existing group (which minimizes adverse selection), but to give them two or three options to choose from. This allows members to opt for the coverage level that they would prefer and increases the likelihood that they will receive sufficient information to make informed decisions. Care must be taken not to give too many options or to make the options too diverse because higher-risk individuals tend to maximize coverage, thus reducing the gains of compulsory participation.

Another approach, sometimes found among MFIs, is to make coverage all-or-nothing at the borrower group level, such as a village bank. For example, in the initial FINCA-AIG arrangement in Uganda, all members of the village bank had to agree to the coverage or none got it – this simplified the administration and created an adverse selection control since individuals could not opt in or out.

2.3 Individual insurance

At the other end of the spectrum are the aforementioned memberships of BRAC's MHIB and Grameen Kaylan in Bangladesh. Although many of the members come from the associated MFIs, the schemes also recruit the general public at slightly higher premium and co-payment rates. These are examples of individual microinsurance (since there is optional participation), as are the endowment policies offered by Tata-AIG (India) and Delta Life (Bangladesh). Individual microinsurance is possible, but it requires a high participation rate among the potential target market to attain desirable financial results.

Individual insurance can cost more than twice as much as group coverage because of higher sales, underwriting, administration and claims costs. Individual insurance claims costs can be reduced through more rigorous underwriting, such as medical screening (since the bad risks are identified and fil-

tered out or are limited to lower coverage). For microinsurance, however, this screening may not make economic sense because coverage amounts are very low, and it may also contradict the social agenda.

Therein lies the crux of making microinsurance work. It is relatively easy if the targeted population is a well-organized group that can accommodate group insurance arrangements, but is quite challenging if it is not because of the higher delivery and claims costs. Under what circumstances would individual microinsurance make sense? It makes sense when a group is covered by a compulsory life product already and then some members of the group would like to have additional, elective coverage. Individual coverage may also be justifiable, but expensive, when the target population is unorganized.

A key advantage of individual insurance is that the individual can continue to be covered once group membership ceases, for example MFI clients who no longer require loans. Group covers can be converted into individual policies using continuation options. To the extent that the group cover relies on infrastructure supporting the group (e.g. using the MFI's mechanisms for premium collection), continuation policies may produce additional charges and administration.

As discussed below, individual insurance can be made more viable with product design features that limit scope for adverse selection, including health declarations, waiting periods and incremental benefits. For the low-income market, individual covers may also be possible if technology can be employed to minimize the operating costs, although such examples were not identified in the case studies.

2.4

To include or not to include

A unique aspect of microinsurance is the willingness to be broadly inclusive. Generally, commercial insurers limit their exposure by excluding high risks, such as older persons or those with pre-existing conditions. The microinsurance challenge is to find ways of serving vulnerable households at affordable rates over the long term. There are several issues to consider:

- Broader inclusion has marketing and social appeal. In some contexts, the target market prefers to subsidize high-risk individuals (e.g. as the members of Dong Trieu Mutual Aid Fund in Viet Nam indicated in a recent survey; also seen in Indonesia (McCord et al., 2005b) and Cambodia (McCord, 2001)), whereas in other contexts there is a greater preference for exclusion to reduce premium costs.

- Broader inclusion produces lower operating costs by reducing the costs of screening, while accepting higher-risk persons and their accompanying claims costs. Significant volumes of policyholders are required to justify this approach.
- High-risk individuals can be included if the benefits are limited or, alternatively, if premiums are correspondingly higher for risky members than for the rest of the group. Both of these approaches reduce the cross-subsidization of the higher-risk individuals by the remaining members and support broader inclusion on a sustainable basis.
- There is a solid economic rationale in play as well: the costs of monitoring and enforcing complex exclusions must be weighed against the claims avoided; the small sums insured and premiums of microinsurance products cannot support complex screening and claims validation.

While schemes are often willing to accept high-risk members, they might not be so inclined to keep older policyholders. Most schemes have age ceilings – 60 years old at VimoSEWA and 67 years old for ServiPerú's hospitalization benefit – although some, like UMSFG, have no age limitations. To soften the blow of asking members to leave the scheme (just when they are about to really need the benefits), some microinsurers such as CARD MBA and Yasiru (Sri Lanka) provide a withdrawal payout.

Funding older members may or may not be feasible. The tradeoff is between lower premiums in order to market the programme more effectively to all, or higher premiums in order to be more inclusive. If the intention is to be inclusive, should everyone pay higher premiums, or should older members pay higher premiums or receive lower benefits in order to minimize the subsidization by younger members? The best solution, as with other tradeoffs, is to explain the differences between the cost of lifelong membership versus having an exit age, and then let the prospective policyholders decide.

3 Terms and payment options

3.1 Term of the coverage

Many microinsurance products are for 12 months or less. These short-term policies are generally preferred by insurers because long-term insurance involves more permanent commitments and higher risk – it is easier to predict the likelihood of an insured event in the next year than the next 10 years. An insurer needs to be conservative when giving medium- to long-term guarantees, and must ensure that significant margins in the rates are included to compensate for error (*see Chapter 3.5*). From a regulator's perspective, long-term coverage is more closely supervised because of the devastating com-

pounding effects that erroneous interest rate and mortality assumptions can have on the insurer.

For the insured, the advantage of long-term coverage is that he/she will have protection even if a condition develops. On the other hand, it is generally more expensive in the younger years than renewable term coverage.

If insurance is offered together with a loan, it is generally recommended that the loan and insurance terms end at the same time so that the client has an opportunity to renew them together. In Zambia, CETZAM and NICO Insurance had an interesting arrangement whereby the insurance coverage continued for two weeks after the loan term so that borrowers could retain insurance cover between loans, since there is often a short gap between the end of one loan and the beginning of another.

Where the insurance term is significantly longer than the loan term, however, organizations have a problem with lapses. For example, Tata-AIG initially sold its five and 15-year life insurance policies through microfinance institutions. However, of the nearly 10,000 policies sold in 2002–3, only 14 per cent were still active in 2005. The high lapse rate is largely attributed to clients who stop borrowing, and if they are not borrowing, the MFI does not have an administration system to continue collecting premiums.

Short-term covers can have a renewable-term arrangement whereby the policyholder can continue to have coverage up to a maximum age without additional underwriting or applications, as long as premium payments are made. Renewable terms combine the advantages of both short- and long-term coverage. The insured are guaranteed continued coverage, yet the insurer can adjust the pricing, up or down, depending on its experience. The renewal option may be subject to adverse selection in that policyholders more likely to claim are more likely to renew their cover, and this may need to be factored into pricing.

Local preferences are important in determining the term. Microcare in Uganda has migrated from four-month term products (matching loan cycles) to annual cover in response to client demand. Conversely, VimoSEWA had the opposite experience. Historically it only offered twelve-month insurance cycles, but it is now experimenting with three-month terms as clients wanted more regular premium intervals and coverage renewal. In general, short terms have high operational costs, as well as the significant cost of non-renewals because the shorter the term the more frequently the client has to make the purchase decision and the less time there is for the demonstration effect to make itself felt.

3.2 Premium payment frequency

The microinsurance target market often has irregular and unpredictable cash flows. To minimize lapses (and maximize renewals), the premium payment mechanism has to find ways of timing payments so that they correspond with periods when the households have some surplus income.

When Delta Life began offering microinsurance, it assumed that the poor needed to pay premiums on a weekly basis, because that is what they did at Grameen, BRAC and the other Bangladeshi MFIs. To make this possible, Delta employed field staff to go door-to-door to collect premiums from all the policyholders at their homes or workplaces each week. Not only was this method extremely expensive for Delta, but as it turned out, it did not quite meet the needs of its clients either. When Delta introduced monthly, quarterly, semi-annual and annual payment options, it found that different segments of the market had different preferences.

When determining premium payment schedules, another factor to consider is the time value of money. As described in Chapter 3.5, when insurers receive premiums in advance, they can invest them; the returns on that investment are used at least in part to keep the cost of the insurance down. So generally, insurers prefer up-front premium payments instead of instalments.

From the insurer's perspective, up-front payments also eliminate or reduce problems with lapsed policies. Lapses occur when a policyholder neglects to make a premium payment within a certain period of time, similar to a borrower missing a loan repayment.³ The big difference with a loan repayment is that the lender still wants to get its money back; whereas a lapsed policy could work out to the financial advantage of the insurer that has taken money from the policyholder but is no longer obliged to provide insurance benefits, as illustrated in Box 26.⁴

Box 26

Lapses at Delta Life

From the start, Delta's microinsurance products have been voluntary. The fact that the insurer has sold nearly 2 million policies over the years suggests that there must be some level of customer satisfaction. Yet less than half of those policies are still in force, which possibly reflects the lack of a connection between product design and customer needs. A reasonable measure of customer satisfaction might be continued payment of premiums. When peo-

³ Lapses are a problem with long-term policies with premium instalments. For short-term insurance, the corresponding concept is a non-renewal.

⁴ Typically, a lapsed policy can be brought back into force by payment of outstanding premiums and through additional underwriting.

ple become dissatisfied, they may stop contributing. Certainly other factors also cause lapses, but it is still a reasonable indicator of dissatisfaction.

Of the 1.9 million policies sold by Delta Life up to September 2004, 57 per cent are inactive. In some cases, this is due to maturities and settlements. Inactive policies could result from changes in the customers' financial situation, or differences between what they thought they were buying and what they did buy. Alternatively, the cause may simply be dissatisfaction with the product. Customers have complained about delays in claims processing and claims being paid by crossed cheque, which means that they have to open a bank account. Some policyholders also compare Delta Life's returns unfavourably with those of banks.

Management recognizes that it has a problem with lapses. In the past, lapses have not been a priority, perhaps because the organization benefits financially when policies lapse. Field staff were not monitored or rewarded on the basis of the number of policies that remain in force, and they have not received training on how to encourage timely payments. Delta anticipates, however, that reengineering and better management information will improve the situation.

Source: Adapted from McCord and Churchill, 2005.

As described in Chapter 2.2, with endowment policies, one way to prevent lapses is through a non-forfeiture clause. Similarly, the primary product for a mutual benefit association in the Philippines, as required by law, is life insurance with compulsory participation of all MBA members. According to the regulations, 50 per cent of the gross premiums must be set aside as member equity. If a policy lapses, however, then the equity can be used by the MBA as a premium loan so that coverage is continuous, at least until the equity is consumed. If the member then wants to reinstate, he/she is required to first replenish the borrowed equity. Clearly, this cannibalism of policy value undermines the usefulness of insurance as a long-term savings vehicle, but at least the cover remains in force.

3.3 Premium payment mechanisms

As discussed in Chapter 3.3, besides minimizing lapses and non-renewals, the other critical factor to consider when designing premium payment methods is to keep the administrative costs (and the transaction costs to the customer) as low as possible. As a general rule of thumb, the best time to collect premiums is when policyholders have cash, for example at harvest time, or when they receive a loan or a government cash transfer. Even better, collect

the premium at the source so that premiums can be bundled for multiple clients. For example, Yeshasvini in India collects premiums from producers' cooperatives who deduct the amount from the members' incomes.

Group cover has the advantage of streamlining the premium collection process: there may be only one central policyholder, who pays a premium on behalf of many persons. The collection of premiums is effectively outsourced to this policyholder.

To streamline premium payments, another common strategy is to “piggyback” the premium on top of another financial transaction. For example, one of the easiest ways to achieve the high renewals and minimal administrative costs is to link the premium payment to a loan, since clients have cash when they receive the loan and can easily pay the premium. The downside of relying on this approach is that only clients who receive a loan can get insurance coverage.

Another approach is to deduct the premium from a savings account, which is done by La Equidad in Colombia and others. This approach is strongly recommended in Chapter 2.3, as long as customers know that the money is being deducted. Another more innovative link between savings and insurance is to establish a fixed deposit account and allow the interest to pay the insurance premium, a strategy that VimoSEWA uses successfully. One challenge with this method is for the poorest clients to save up enough money to deposit in the account.

What does an insurer do when its clients do not have a regular place to live and work, let alone a bank account? There are other ways of piggybacking besides financial transactions to reach a clientele in the informal economy. For example, African Life found that many clients for one of its low-end products in South Africa had a common regular practice: going to church every Sunday. So it issued “pass books” to customers which they have stamped at the church when they pay their weekly premiums.

3.4 Premium amounts

It is standard practice for insurers to apply different premium rates depending on the policyholder's age and sex, especially with individual insurance. For microinsurance, this adds a layer of complexity that can be difficult for staff and clients to understand. Within the context of the partner-agent model, several MFIs, including TSKI (Philippines) and Shepherd (India), have negotiated with insurers to provide a single rate for all ages (*see Box 27*).

Such an arrangement is possible when the sum insured is small, if there is a continuous influx of younger members, if there is a maximum coverage and/or entry age, and with annual actuarial pricing review. For higher-value

policies or with elective participation, the MFI will probably have to implement age-structured rates prepared by the insurance company or actuary.⁵

Whatever the premium terms, it is difficult to overstate the importance of managing premium delinquency. Many insurance schemes have failed because they provided cover without actually collecting premiums.

Box 27

Flat-rate pricing for Shepherd

When Shepherd was developing its hospitalization product with United India Insurance Company (UIIC), one of the sticking points in the negotiations was the age brackets that the insurer proposed. Initially, UIIC wanted to offer a lower premium for members between 18 and 45, and charge those in the 46 to 60 age bracket a higher price. As is its custom, Shepherd took this proposal to its members and they voiced significant concerns, preferring instead a uniform price. Given the complications that arise from trying to determine a person's age in rural India, and the administrative costs and challenges of segregating policyholders into two categories, this was probably a fortunate choice.

Source: Adapted from Roth et al., 2005.

4

Benefits

The benefits provided by the insurance product should be largely determined through demand research: what is it that people need coverage for? The general lesson is that microinsurance benefits should be kept as simple as possible for several reasons. First, to keep the premiums low, the administrative costs have to be kept low; and it is easier to accomplish that objective if the benefits are straightforward. More complicated products could be managed cost-effectively if the organization had an excellent management information system, although this is not an area in which microinsurers have as yet excelled.

Second, the target market for microinsurance is often illiterate or uneducated and lacks exposure to insurance. Complicated benefit packages are difficult and time-consuming to explain to clients. Indeed, one of the reasons why the new products introduced by ALMAO in Sri Lanka have not been popular is that they are harder to explain to customers than the old basic funeral insurance product.⁶ If a product cannot be easily explained in a few sentences, then low-income clients will not understand it and the product

⁵ Although flat-rate pricing may be preferred from an operational perspective, Chapter 3.6 describes why it is not the ideal approach for financial risk management.

⁶ Another reason for the limited demand is because the new products are more expensive since they include an accumulating value component.

will not be well received. In fact, where the benefit package is complicated, salespersons tend to omit to mention certain benefits.

Another reason for keeping the product simple is that many of the bells and whistles in complicated products are really just there as window-dressing, used for marketing purposes to make the product appear more impressive. In practice, however, there are hardly any claims for certain benefits, and therefore people are paying for things that they do not really need or want. For example, ASA was offering insurance in partnership with Life Insurance Corporation (LIC) of India that provided multiple benefits (*see Table 17*) for an annual premium of just Rs.100 (US\$2.22). The problem from ASA's perspective was that the insurer would hardly ever pay accidental death claims, as elaborate documentation was required to prove that death had been due to an accident, and hardly any clients made disability claims. Therefore, when ASA switched insurance partners, the MFI simplified the benefits, requesting only death cover, regardless of the cause, and no disability benefits.

Table 17

Benefits of LIC's Janashree Bima Yojana

<i>Insured event</i>	<i>Sum insured</i>
Natural death	Rs. 20 000 (US\$444)
Accidental death	Rs. 50 000 (US\$1 111)
Partial disabilities	Rs. 25 000 (US\$556)
Total disability	Rs. 50 000 (US\$1 111)

Source: Roth et al., 2005.

When determining insurance benefits, it is important to ask whether it will be easy for policyholders to make a claim. If the client cannot make a claim, or at least not easily, then the proposed benefit will not be particularly beneficial. This logic has led others to follow ASA's lead in staying away from accidental death coverage and disability benefits. Leftley (2005) agrees that disability benefits should not be included in microinsurance: "Many clients cannot claim for disability because they are unable to demonstrate that it was not a pre-existing condition as they lack formal medical records. Plus, trying to explain that they get 50 per cent of the sum insured for one arm, and 25 per cent for an eye, and so on, is also complicated and off-putting for a newcomer to insurance."

In contrast, CARD MBA does offer additional accidental death benefits (*see Table 21 below*). Since it is a member-owned scheme, it is easier for peers to assess if indeed the death was accidental even without a police or coroner's report, which are difficult to come by on remote Filipino islands. CARD MBA also follows a simple rule regarding claims settlement: "When in doubt, pay." Such an approach helps build member confidence in the scheme.

Although the benefits should be simple and “claimable”, microinsurers should also consider offering a couple of different benefit levels so that the low-income market can experiment with a very basic and inexpensive product. If they come to believe that insurance provides good value for their money, they might be enticed into higher benefit levels. This graduation from entry-level products to more substantive benefits would be a strong indicator of customer satisfaction and loyalty (and possibly an adverse selection risk!).

4.1**Basket coverage?**

In India, which is perhaps the world’s most sophisticated microinsurance market, there is a trend toward basket coverage, whereby a number of benefits are all thrown into one integrated insurance policy. For example, VimoSEWA’s product covers death, hospitalization and asset loss – benefits that come from two different insurance companies – all bundled together into one comprehensive product (*see Table 16 in Chapter 2.4*).

Table 18 summarizes the benefits of an insurance policy provided by UIIC to Shepherd. The core benefit from this product is the hospitalization cover. Although this is a relatively new product without a lot of claims experience, it is unlikely that there will be many claims for most of the other benefits. If that is indeed the case, then clients are paying 20 to 25 per cent more than they should for the hospitalization benefit. Indeed, one problem with basket coverage is that policyholders may be buying benefits that they do not want (although this does have the advantage of reducing adverse selection).

The rationale behind a bundled product is that it delivers a more comprehensive risk protection package while reducing expenses (i.e. it would be more expensive to sell three separate products). The marginal cost of adding additional benefits is minimal. Plus, when selling the product, the salesperson can offer a cost-effective solution to the diverse risk-management needs of the target market.

One major issue with this basket cover approach is the lack of transparency. Clients would never be told the contribution of each individual benefit to the total price, nor would they be allowed to choose the specific benefits they want. Another potential problem is that the inadequate servicing of one component of the product may taint the perception of the entire product, since the life and non-life risks are usually ceded to different companies. So if health claims are not paid on time, for example, the whole package will be affected. The converse is also possible: good servicing and good value of one component could increase the appeal of the entire package, so that an inferior component is propped up, at least for a time.

To summarize, this is an unresolved issue, as the attraction of providing more comprehensive coverage is in conflict with the compelling rationale for keeping the product simple.

Table 18

Benefits from UIIC's UniMicro insurance scheme

<i>Product feature</i>	<i>Comment</i>
Group or individual	Group
Term	1 year
Eligibility requirements	Age 18 to 60 Declaration of good health
Delivery model	Partner-agent with UIIC
Voluntary or compulsory	Voluntary
Product coverage (benefits)	Rs. 15 000 (US\$333) accidental death Rs. 15 000 (US\$333) permanent disability Rs. 250 (US\$5.55)/month up to max Rs. 750 for temporary disability Rs. 5 000 (US\$111) hospitalization expenses Rs. 5 000 (US\$111) for house fire and allied perils
Key exclusions	30 days waiting period (except for accidents); exclusions for the hospitalization cover include childbirth, pre-existing conditions, and HIV/AIDS; during the first year of the cover, treatment for cataracts, hysterectomy, hernia, congenital internal diseases are not payable, but these are covered from the second year
Pricing	Member pays Rs. 100 (US\$2.22); Rs. 84 (US\$1.87) goes to the insurance partner; Rs. 16 is kept as commission (an additional Rs. 20 (US\$0.44) is charged for thatched-roof houses)

Source: Roth et al., 2005.

4.2 Family benefits

While it may be appropriate to have fewer benefits, it is also (generally) better to have more people covered by one product. A family benefit approach, which may include spouses, dependants and even parents, creates a number of important advantages for microinsurers:

- A family is a group of sorts, and consequently family coverage carries many of the same advantages as group coverage: larger numbers, lower adverse selection risk, etc. The price for a family unit is generally lower than the sum of individual premiums.
- Family coverage can have a positive selection effect by purposefully enrolling very low-risk persons. For example, African Life entered the HIV/AIDS-ridden low-end market by developing a product where the family, rather than an individual, was the insured unit.
- Family coverage often has a better marketing effect because claims are more frequent and thus there are many more examples to demonstrate the value of microinsurance.
- Microfinance institutions concerned about protecting their loan portfolio realize that borrowers have repayment problems when death or illness strikes family members.
- If the whole idea behind microinsurance is to reduce the vulnerability of low-income households, then coverage should be extended to include all household members.

The disadvantage of family benefits is that not everyone has a family, or that some people have larger families than others. To deal with the size of the family, microinsurers either ask the policyholder to identify the specific dependents who are covered by the policy or they offer different prices for different-sized households. To ensure that women and children are not left out, it is preferable to require family coverage where possible.

ALMAO's funeral policy covers up to nine people, including parents and in-laws. CARD MBA covers the spouse and up to three children under 21. Those without children can include their parents. For those who are not legally married, CARD assists by organizing weddings (*see Box 28*). Another disadvantage is that family benefits are more expensive in absolute terms (though possibly not in per capita terms), which may make coverage unaffordable for some market segments.

Box 28

Mass weddings

CARD MBA requires that for coverage of other family members there must be legal documentation to prove the relationship. Many MBA members have not yet formalized their relationship with their spouse, often because of the costs involved. Thus, as a member benefit, the MBA occasionally organizes mass weddings for its members. This event helps members comply with MBA requirements, puts women in a better legal position, and saves them money.

Source: Adapted from McCord and Buczkowski, 2004.

One cannot assume that households have nuclear families of mother, father and two children. Depending on the country, many households contain extended families including grandparents, nieces, nephews, aunts, the children of friends, etc., particularly in HIV/AIDS-ravaged areas where grandmothers are taking care of orphans. Consequently, microinsurers have to be very clear who they consider to be a dependant, relying on local definitions where possible (*see Box 29*).

Box 29

UHC definition of family in Uganda

When it agreed to sponsor the development of the Uganda Health Cooperative, management at Health Partners, a United States-based HMO, expected that many of its North American assumptions and ways of doing things would have to be adapted to the Ugandan context. One adaptation that was quickly deemed necessary was the definition of who was included under “family” coverage. The North American definition of family did not accurately reflect the reality of the lives of potential Ugandan policyholders. Instead, UHC developed a more “local” definition: “everyone who eats from the same pot”.

Source: Adapted from Brown and Churchill, 2000.

For example, TSKI and its insurance partner Cocolife agreed that children born outside wedlock can be included in the policy as long as they share the same family name as the TSKI client. Illegitimate children with a different family name cannot be included. However, children from previous marriages who have different names can be included under the microinsurance as long as there is documentation to prove that they are the client’s biological children. This example is not necessarily a good or bad practice, but it illustrates the types of issues that will need to be clarified under a family coverage.

Even more important than defining which dependants are eligible, is to identify them in advance. To minimize claims fraud, each person covered by the policy must be individually identified using official documents (where possible) and/or with photographs. It is not sufficient to specify which persons are covered without combining this with explicit identification of the additional persons. It is also important to control movements of dependants on or off the policy. For example, clients may have the option of adding newborn children to the policy at birth (or within a short timeframe thereafter) but not subsequently. This controls adverse selection.

When extending life coverage to spouses, it is important to recognize that men often have higher claims ratios. For example, in AIG Uganda's experience, the claims ratio of men to women is 4:1, while at CARD MBA it is 3.2:1. Spandana has had similar experiences. There are various factors involved, for example men tend to be older than their wives, while having a lower life expectancy. However, there also appears to be a screening problem. In each of these cases, the women are borrowers who have to meet specific criteria, e.g. less than 55 years old, economically active and accepted by their borrower group. However, no screening or age restrictions are applied to spouses, which leads to an adverse selection scenario in which women with sick husbands can join the scheme.

4.3 Cash or in kind? Now or later?

With health insurance, benefits are either conveyed in kind, in which case the benefit is the healthcare service, or in cash. Cash healthcare benefits are usually paid on a reimbursement basis; the policyholder has to pay the bills and then submit the receipts for reimbursement. Such an arrangement is generally less appropriate for poor clients who do not have the money to pay the bills in the first place (*see Chapter 2.1*).

The benefit of having health insurance is that people do not have to delay care because they have to find the money. Most community-based health insurance schemes use a third-party or cashless payment system whereby the microinsurer pays the healthcare provider directly, so the insured does not experience any out-of-pocket expenses, except perhaps for a co-payment or transportation (which is sometimes also reimbursed by the insurer). Health insurance on a reimbursement basis is a distant second-best option.

In Georgia, where Aldagi Insurance is in partnership with Constanta Foundation, policyholders are given cash in the hospital so that they can pay the bribes required for care (which are unreceipted and thus not payable to the hospital or reimbursable to the beneficiary). While this approach may not be recommended in other contexts, it illustrates the inventiveness required to serve the low-income market.

For life insurance, benefits are almost always paid in cash, although there are some interesting exceptions. ServiPerú's coverage is paid through funeral services, which includes a coffin, flowers and a hearse. In fact, ServiPerú has found the low-income market more receptive to service provision because it is easier for it to understand than risk pooling. One advantage of the in-kind approach is that the insurer can arrange a discount by essentially buying the funeral services in bulk, so low-income households can get better value for

their money. The disadvantage is that, when a death occurs, the family often has to pay for other expenses besides the funeral, and therefore needs a cash payment as well.

Another factor to consider with life insurance benefits is when they are paid out. Typically, after a claim has been processed, the beneficiary gets a lump-sum benefit and that is it. If a breadwinner has died, the household will have to find ways of replacing the lost income. Under such circumstances, a lump-sum benefit could quickly disappear. To address this issue, La Equidad provides households with several benefits. Besides a payout if the policyholder dies or is permanently disabled, its *Amparar* (Spanish for “to protect”) product – offered to the low-income market through the MFI Women’s World Foundation – also provides financial support to help beneficiaries pay for groceries and utilities (see *Table 19*). For an additional premium, policyholders can purchase a children’s education rider that would make additional monthly payments for two years to assist with education expenses.

Table 19

Benefits of La Equidad’s *Amparar* microinsurance product

Coverage (US\$)	Plan 1 Smallest	Plan 6 Largest
Death (any cause)	1 244	8 292
Total and permanent disability	1 244	8 292
Food/groceries for 12 months	25	104
Utilities for 12 months	12	62
Funeral support (lump sum)	62	332
<i>Optional:</i>		
Children’s education expenses 24 months	15	75

Note: there are six plans. Only the smallest and largest are included.

Source: *Almeyda and Jaramillo, 2005.*

The provision of benefits over a period of time after the insured event is likely to have a greater development impact than a lump-sum payment, which may be spent on an elaborate funeral but not help the household cope with the loss of income. The staggered benefits approach is also adopted by ALMAO’s “Senehasa” product (see *Chapter 2.4*) and CARD MBA’s total and permanent disability (TPD) cover, which pays out over an 18-month period. The main disadvantage of staggered benefits is the transaction costs involved, especially if they are provided by cheque which might be difficult for beneficiaries to cash. This disadvantage can be overcome if benefits can be paid directly to a savings account, or to a service provider such as a grocery store or utility company.

4.4

Cash-back benefits

As mentioned above, one of the difficulties in marketing microinsurance is to convince clients that they are getting value for money, even if they do not claim. Policyholders are often left with the perception of poor value if they pay premiums for some time without receiving any benefits in return, not recognizing the importance of having enjoyed the security and protection. This may be especially true if the insured becomes too old and is forced to drop out.

To help address this problem, some benefit features may be added to longer-term products, such as those described in Chapter 2.2, although these may introduce pricing risks typically inherent in most long-term guarantees (see *Chapters 3.5 and 3.6*):

1. Premium-back features generally refund all or part of the premiums paid after several years of enrolment, as is required under the MBA regulations in the Philippines. If the term is long enough, a modest interest payment may even be included. Yasiru (Sri Lanka) does this as well, distributing 40 per cent of its profits to clients with at least five years of membership, which serves as a loyalty incentive.

2. Paid-up insurance means that after several years of premium payments, the coverage may continue for a lifetime without additional premiums. The amount of insurance may also be determined by the entry and exit age of each client. For example, with ALMAO's "Pilisarana" product, premiums are paid until the policyholder turns 60. The benefit after that age depends on how old they were when they started paying into the scheme.

3. Savings features may be bundled with the product and contributions returned with interest dependent on the net earnings of the portfolio. It may be difficult to market a non-guaranteed interest rate, but this can be done with hypothetical projections.

4. Endowments pay a guaranteed cash benefit, perhaps equivalent to the life coverage amount for a certain period of time or when the policyholder reaches a certain age.

These features tend to be relatively expensive and potentially risky for the insurer if not designed properly, especially if interest rates are low or in decline. Although "no claim" or persistency-linked cash-back awards may seem attractive to clients, like any other benefit, they must be charged for, and effectively reduce the risk spreading of insurance, which is to redistrib-

ute resources from those unaffected by the risk to those affected by the risk. In addition, care must be taken to keep the product simple when introducing such features to preserve its appeal.

5 Risk management and claims controls

For both health and life insurance, it is essential to design products with the claims controls and adverse selection features to sustain the scheme and keep premiums low. In general, elective participation, diverse target populations, broader inclusions and numerous product choices all tend to increase adverse selection and thus need more controls, especially in smaller schemes.

The principle of simplicity that applies to benefit design and marketing is also applicable to risk management and claims controls. Insurers seem to have an inherent tendency to make things complicated, a tendency that microinsurance must curtail. For risk-management purposes, product options should not be choices at all, but rather pre-defined and linked to circumstances outside the applicant's immediate control. For example, if applicants have a family, then they should be required to take the family package.

Other key controls to consider include health declarations, co-payments and deductibles, and microinsurance-friendly alternatives to exclusions.

5.1 Health declarations

If the potential for adverse selection is significant, then the applicant should be required to sign a declaration of good health, an approach used by many of the organizations that offer life insurance. It is even useful with credit life to discourage older or sick borrowers from attempting to maximize their loan amounts once they become aware of a terminal disease such as cancer.

The basic idea of a health declaration is that the applicants state that they are in good health to the best of their knowledge at the time of application. If policyholders then die and the microinsurer can determine that they knew about the terminal health condition at the time of the declaration but lied about it, then the microinsurer has the right to deny the claim based on the false declaration. So instead of expensive screening of all applicants, the insurer concentrates its resources on verifying a few claims.

The health declaration is useful not only as a tool for the microinsurer to reject claims, but also as a deterrent to adverse selection. For example, if a terminally ill loan applicant knows that the credit life claim is likely to be declined because of the declaration, then he/she may be discouraged from proceeding with the loan application because of the burden that will be put on the surviving family.

For credit life, health declarations may either be required for all loans or only for larger loan amounts. For efficiency purposes, microinsurance schemes minimize controls for the smallest policies, but introduce them for larger sums insured. If only required for larger loans, the microinsurer will still have some exposure to adverse selection, but will put up with it to save the administration costs involved in processing a declaration for every single loan. In such cases, the trigger for a declaration should be based on the total amount of all outstanding loans granted to the borrower rather than each individual loan.

5.2 Co-payments and benefit ceilings

For health microinsurance, deductibles and coinsurance (which are different types of co-payments) and benefit ceilings are important claims control mechanisms. The most effective design combines all three. That is, all claims below a certain amount, the deductible, are paid by the insured. Then, the insured pays a coinsurance of x per cent of the claim (or a fixed amount) in excess of the deductible. The insurer pays the difference up to a certain maximum amount. These control mechanisms can be applicable to each claim or on an annual policy-year basis.

The point of such payments is two-fold: 1) to reduce the actual claims amount paid by the insurer, and perhaps more importantly 2) to help reduce the claims incidence. For example, insureds will be more reluctant to admit themselves to hospital for minor ailments if they have to pay a deductible, and would also be discouraged from remaining hospitalized beyond the necessary period if a coinsurance were payable in excess of the deductible.

An additional objective of a deductible is to reduce the administrative burden for the insurer of processing many small claims. So if a deductible were in place, the insurer would only process claims that were in excess of the deductible. Interestingly, although coinsurance is common in microinsurance (see Table 20), none of the case study organizations included deductibles. The UMSGF *mutuelles* did use deductibles initially, but when the network introduced a third-party payment system where the insurer reimbursed the healthcare providers directly, deductibles were no longer considered necessary because the administrative processes were sufficiently simplified. From a pricing perspective however, all claims should be coded in an MIS, whether or not the deductible is exceeded, whether or not a claims payment is made. This is necessary to determine true morbidity rates and medical costs (see Chapter 3.5).

Healthcare schemes that only provide inpatient benefits may find co-payments unnecessary as well. For example, Yeshasvini, which only covers sur-

gery, does not require either since it assumes that people will not have surgery unless they really need it (and elective surgery is excluded). Similarly, neither VimoSEWA nor Shepherd has a co-payment for their hospitalization covers.

Table 20

Coinsurance and payment ceiling of health microinsurers

<i>Health insurer</i>	<i>Coinsurance</i>	<i>Benefit ceilings</i>
UMSGF	<ul style="list-style-type: none"> · US\$0.38 for outpatient · none for inpatient · 30% for primary care 	none
AssEF	30% of expenses for specified in- and out-patient services	none
BRAC MHIB	<ul style="list-style-type: none"> · US\$0.03 for MFI clients · US\$0.08 for other insured persons · none for the ultra poor 	between US\$8.52 and US\$17.04 for each incident when referred outside the BRAC clinics
Grameen Kalyan	<ul style="list-style-type: none"> · US\$0.09 for MFI clients · US\$0.17 for non-clients · US\$0.85 for uninsured persons 	US\$34.08 for hospitalization due to maternity complications, and to US\$17.04 for hospitalization due to other complications
Yeshasvini	None	US\$4,545 per year which is sufficient for two of the most expensive operations and some smaller ones
ServiPerú	<ul style="list-style-type: none"> · US\$1.43 per consultation (except for X-rays the policyholder pays 50% of the cost) · US\$11.43 per emergency service. · 10% of expenses for medical care in the event of accident and hospital care as a result of illness or accident. 	none

The co-payments amount must be carefully determined. If it is too high, then the tendency may be for the insured to wait too long to seek treatment, or not to seek treatment at all, thus possibly causing the condition to deteriorate to a more severe illness, eventually resulting in a much larger claim or perhaps even death. When considering co-payments (or deductibles), microinsurers should bear in mind “implicit” co-payments – for example the costs of travel to access healthcare services or losses of income from time away from business, which may already act as disincentives to unnecessary claims.

Another consideration for co-payments in particular is whether the infrastructure is in place to accept cash payments. For example, three of the four

government schemes analysed in Latin America also avoid co-payments because financial transactions open up vulnerability to fraud (Holst, 2005a).

For health insurance, several organizations control claims by instituting a maximum claim per annum or per hospitalization, or by limiting the number of hospitalizations per annum. BRAC and Grameen Kalyan apply these limits when cardholders have to be referred to other healthcare providers, but do not limit the amount of care from their own clinics. Yeshasvini Trust has a maximum amount that can be claimed in a calendar year (US\$4,545). These controls protect the viability of the scheme – especially since the schemes do not have reinsurance – but limits cannot be set so low as to undermine the usefulness of the insurance cover.

5.3 Alternatives to exclusions

Insurers may use exclusions for a number of reasons:

- Controlling adverse selection, e.g. pre-existing condition exclusions
- Reducing moral hazard, e.g. suicide exclusions
- Reducing the cost of insurance by removing high-frequency or common claims and targeting only specific causes of claims, e.g. accident-only cover which excludes death due to illness
- Controlling covariant or catastrophe risk, e.g. war and riot or weather catastrophe exclusions
- Reducing the extent of initial underwriting, e.g. one-year HIV/AIDS exclusions applied to life cover to eliminate the need for testing

As discussed above, microinsurers may adopt a different approach to exclusions from that of traditional insurers. While the moral-hazard exclusion is justifiable regardless of the type of insurance, a microinsurer may allow typically excluded conditions for covariant risk and certain adverse selection risks in the spirit of social protection.

Where covariant risks are taken on, it is essential that appropriate risk-mitigation strategies exist, such as reinsurance or donor support in the form of guarantees. Otherwise, the only consequence of dropping the catastrophe exclusion will be the insolvency of the scheme in the event of a catastrophe, which benefits no one.

The argument against exclusions for pre-existing conditions is not quite as clear. If a microinsurer offers voluntary individual insurance, then high-risk people are most likely to sign up; if only high-risk people join, the insurer cannot effectively pool the risk. However, if it is group coverage, especially if it is mandatory, or the microinsurer recruits large volumes of policyholders,

then it can be more inclusive with regard to pre-existing conditions. This additional risk is highest at product launch. If renewal/persistency rates can be kept high, as the scheme matures, the risk associated with pre-existing conditions becomes more manageable because new insureds become a smaller proportion of the entire portfolio. It may be appropriate to fund this start up risk with donor support, which can be relaxed subsequently as the scheme moves towards sustainability.

A microinsurance-friendly alternative to exclusions is the waiting period, whereby policyholders cannot access certain benefits for some time after they enrol. For example, in South Africa, HIV/AIDS-related adverse selection is managed using six-month to one-year accident-only waiting periods for life policies backing up low-income housing loans. A waiting period has essentially the same effect as excluding pre-existing conditions except that the insurer does not have to incur the claims verification costs. If the insured event occurs during the waiting period, the claim is rejected; the insurer does not have to check with doctors and review medical records to determine if the policyholder already had the problem, as it relates to exclusions for pre-existing conditions.

Another alternative to exclusions which is more in-line with the spirit of microinsurance is to offer **benefit schedules** with gradually increasing benefits. For example, if the insured event occurs in the first year, the benefit is small, but if it occurs after the first year, the benefit is much larger. Such an approach is an effective way to control adverse selection while creating an equitable microinsurance scheme that encourages long-term participation and renewal. CARD MBA has adopted this incremental benefits approach, as illustrated in Table 21.

Table 21

Benefit amounts at CARD MBA

<i>Duration of membership</i>	<i>Cause of death</i>	<i>Member (US\$)</i>	<i>Legal spouse and dependants (US\$)</i>
Under 1 year	Pre-existing condition or event during contestability period	18	–
Under 1 year	Non-accidental	55	55
Under 1 year	Accident	182	55
1-2 years	Non-accidental	55	55
1-2 years	Accident	236	55
2-3 years	Non-accidental	302	110
2-3 years	Accident	575	110
Over 3 years	Non-accidental	302	110
Over 3 years	Accident	665	110

Source: McCord and Buczkowski, 2004.

5.4 Fraud control

A final, critical component of microinsurance product design and risk management is a system to prevent fraudulent claims. Products must be designed in such a manner as to support coverage and claims validation with clear objective criteria. One way to implement cost-effective fraud controls in microinsurance schemes is to make use of their relationship with community structures.

In addition, cost-effectiveness needs to be considered from both the insurer and the policyholder perspective. If having sight of the death certificate involves two or three 10-kilometre trips, unofficial fees and a month's wait, is it really necessary if the agent attends the policyholder's funeral?

6 Conclusions

The main messages from this chapter are:

- Microinsurance product design must strike a balance between broad inclusion, appropriate benefits, low premium rates and sustainability (or targeted profitability).
- Products have to be customized to clients' needs and preferences.
- Affordability and product design features have to be considered together.
- Microinsurance is relatively easy if the target market is a well-organized group; significant challenges are faced when trying to serve unorganized individuals.
- Group coverage is generally more appropriate for microinsurance because it minimizes administrative costs, which should lead to lower premiums.
- Mandatory coverage has significant advantages, while its disadvantages can be curbed through marketing and education efforts, and some choice in benefit packages.
- Short-term insurance is generally more appropriate for the low-income market.
- The heterogeneous low-income market prefers a variety of premium payment frequencies and mechanisms.
- It is advisable to limit benefits to the most important insurable risks.
- The spreading of life insurance benefits over a period of time might be advantageous to both parties as long as transaction costs can be minimized.
- If policyholders cannot easily claim for a benefit, then the policy is not very beneficial.
- Deductibles, co-payments and benefit limits are important claims controls for health insurance schemes.
- Product design features like waiting periods and benefit schedules allow microinsurance schemes to include high-risk persons without incurring additional screening costs.

3.2

Marketing microinsurance

Craig Churchill and Monique Cohen

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When designed properly, microinsurance can be a valuable financial tool for low-income clients. Yet even with a strong product, a microinsurance scheme will fail without an effective marketing campaign. When asked about insurance, low-income persons often express ignorance or indicate that they think it is only for rich people. A major hurdle for marketing insurance to the poor is the lack of differentiation between microinsurance and conventional insurance products. The mentality that insurance is only for the rich will persist until microinsurers can adequately differentiate their product in the market place.

Marketing insurance to the poor presents some other challenges as well. If they have had access to conventional insurance (or know of other people who have had insurance), the experience has often been negative, tainted by claims-processing delays, rejected claims and lapsed policies – all of the characteristics that microinsurance product design must avoid. Low levels of literacy among potential clients make marketing the product even more difficult.

Most people, rich or poor, do not enjoy buying insurance because they do not want to think about risks or the pending occurrence of perils. Many do not like the idea of buying peace of mind and then feeling the expense was wasted if the insured event does not occur. However, that idea is even harder to swallow when one is poor, living from day to day, not planning for the future, and without surplus cash to waste.

This chapter is organized into four sections. The first section summarizes the main marketing messages commonly conveyed by microinsurers. The second section reviews the techniques used for conveying those messages. Section 3 considers the important marketing role of after-sales service, and the final section looks at the marketing implications of mandatory insurance.

I Main marketing messages

The first step in designing a marketing strategy is to determine whom the microinsurer is trying to reach, including their literacy and income levels. One important lesson emerging from ICMIF (2005) is that microinsurers should avoid trying to serve too many different market segments since that can require many products and corresponding marketing channels, which can significantly drive up operating costs.

After identifying the target market, the next step is to determine the main messages that microinsurers want to convey. This is accomplished by considering the anti-insurance arguments that the target market might have, and then designing messages to counter those arguments. From the available case studies, four main marketing messages emerge: protection, solidarity, optimism and trust. Unfortunately, given the data available, it is not possible to assess their relative effectiveness, so this section merely describes the most common marketing messages.

I.1 Protection

A main marketing message conveyed by microinsurers is to remind low-income households that they are vulnerable, that people like them incur risks all the time, and if they do not have a way of effectively managing those risks, they will be worse off. This emotional approach often relies heavily on **testimonials** of persons who did benefit and were able to survive a crisis (as well as negative testimonials of those who did not have protection and suffered).

Delta Life (Bangladesh) uses this approach with its new marriage endowment product, which is supposed to benefit the policyholder's daughter when she turns eighteen, either from the savings or, if the policyholder dies during the term, from the insurance benefit. In the brochure for the product (see *Figure 10*), the bride is crying – even though she is getting an appropriate wedding – because her parent is not there to share her joy.

Figure 10 Daughters' wedding insurance plan: Delta Life

কন্যা বিবাহ বীমা পরিকল্পনা
পরিকল্পনা নং-৪৪২

ডেল্টা লাইফ ইনসিওরেন্স কোম্পানী লিমিটেড
গণ-গ্রামীণ বীমা

কেন্দ্রীয় কার্যালয় : বায়তুল আবেদ ভবন, ৫৩ পুরানা পল্টন, ঢাকা-১০০০
ফোন : ৯৫৬৪০৮৯, ৯৫৫৬৫৩৪, ৯৫৭০৩২৪

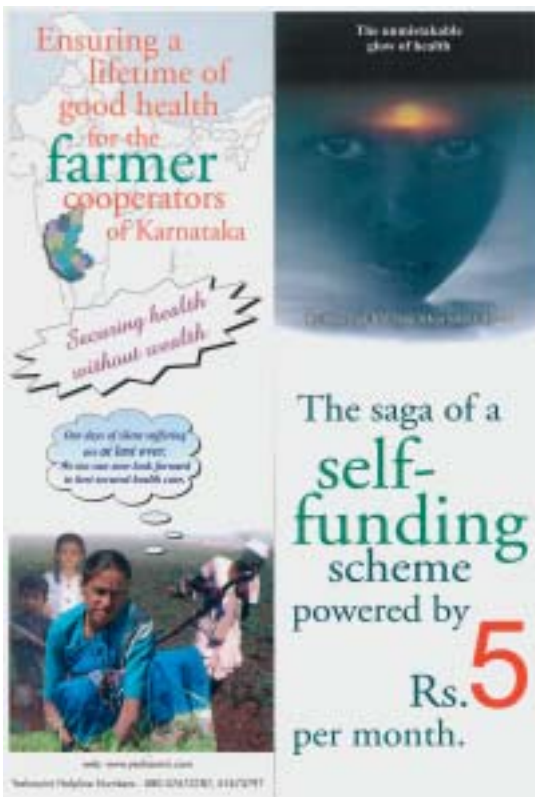
Source: Delta Life Insurance Company Limited, Bangladesh

1.2 Solidarity

While the protection message is essentially the same for insurance and microinsurance, some microinsurers also emphasize solidarity as a key marketing message. This message builds on informal self-help mechanisms, with which people are familiar, to make insurance and risk-pooling more comprehensible to an uneducated market. For example:

- **VimoSEWA (India):** “All contribute to a common pot; those who have faced the prescribed risks can take from the pot as per the rules and regulations decided by all.”
- **AssEF (Benin):** “Mutual health organization! Huge membership + regular payment of premiums = good health for all. Risk management and solidarity for better health.”
- **Yeshasvini (India):** “Each for all and all for each” (see Figure 11).

Figure 11 Marketing brochure: Yeshasvini



YESHASVINI

a simple Scheme
founded on the Principle of Co-operation
"Each for all and all for each".

Special Features

- A member who has been a member of a co-operative society for at least 10 years can avail the benefits of the scheme by paying a nominal sum of Rs. 100/- per year. The wife and children can also avail the benefits by paying Rs. 100/- each year.
- Savings from any kind of insurance is not fact to avail the benefits of the scheme.
- Member age limit to avail the benefits of the scheme is 75 years.
- Member can avail free medical check-up for Rs. 1,00/- only, and Rs. 5,00/- only for routine check-up.
- Life spans of members have been included in the **Healthcare Scheme**, details of which are available at the website.
- Only females who are married with the permission of the husband, but are recognized as **Widows**, **Widely Dependent** or **Orphan** (in absence of the spouse, father, the spouse's father or the spouse's mother) are eligible to become members.

Progress achieved

- In the 1st phase of the project 10,000 new members were enrolled into the scheme. In the second phase, over 100,000 members have been enrolled.
- The first trial version of the scheme was launched in 2007. The first year of operations was completed in 2008. The scheme is now operational in all states of India.
- Over 10,000 members of various banks have been successfully transferred to the scheme's computerized database by 31st December 2008.
- Nearly 10,000 members have been enrolled into the scheme in 2009. In addition, an insurance plan for 2009 has been launched.
- The Health-Insurance has been introduced in over 100,000 members.

Programme for 2009-10

- To attract females and young people in subscription and also build up to provide insurance in the future.
- To take an effective insurance and social awareness among female co-operatives about the scheme.
- Availability of all documents available and transfer of computerized. Family identity cards to beneficiary co-operative members.

The solidarity message is more common, and perhaps more effective, when policyholders are also involved in shaping the benefits and the procedures. This message is particularly important to avoid the confusion that often happens when the policy term comes to an end, and clients who did not suffer the insured event want something back. The challenge is to help low-income households understand from the outset that insurance requires solidarity and that even though they might not benefit this year, they might in the future, and they have made it possible for many others to do so.

1.3 Optimism

Several microinsurers recognize that they need to put a positive spin on their marketing messages since the “doom and gloom” approach can reinforce the negative perspective that poor consumers have of insurance. This positive approach can best be seen by contrasting a smiling girl in TUW SKOK’s brochure (*Figure 12*) with the crying bride from Delta Life.

**GWARANTOWANE
OSZCZĘDZANIE**

OFERTA WAŻNA
OD 01.02.2002r.

**ubezpieczony rachunek
systematycznego oszczędzania**

wysokie oprocentowanie
nie tylko dla zamożnych
poczucie bezpieczeństwa
gwarantowana przyszłość

TUW SKOK
TOWARZYSTWO UBEZPIECZEŃ WSKAZANYCH
SPÓŁDZIELCZYNI KAS Oszczędnościowo-Kredytowych

Figure 12 Guaranteed savings brochure: TUW SKOK

Translation:

- An insured systematic savings account
- High interest
- Not only for the rich
- Feeling of security
- Guaranteed future

This optimistic approach is probably easiest with endowment or accumulating value life insurance policies. The message can focus on the amount of savings that one might have at the end of the term, or on the purposes for which that money could be used – such as building a house, sending children to school or paying for a wedding – instead of on the sum insured that the beneficiary would get if the policyholder died.

The positive spin on health insurance focuses on people being and staying healthy, rather than on illnesses and medical treatments. It is even possible to present term life from a positive angle, by linking the cover, which is relatively inexpensive, to a common superfluous expense. The same idea underlines the slogan for a health insurance scheme in India – “For just a rupee per day” – since it costs Rs. 365 per person annually.¹

1.4 Trust

One of the problems with selling insurance is that policyholders do not know whether the insurer will pay out the benefits in the event of a claim. The market often perceives insurers as quick to take their money, but slow to pay it out. Low-income persons are particularly susceptible to fraudulent schemes, which in some locations have undermined the credibility of legitimate insurers. Even with respectable insurance companies, the low-income market tends to experience a disproportionate amount of claims delays and rejections. This is, in part, because the poor are not a powerful or influential customer base, so insurers do not have significant incentives to keep them happy.

Microinsurers need to find ways of convincing the target market that they are indeed trustworthy. Conventional insurers often try to create large, visible headquarters as a way to convey the impression that they are a large and stable company. Located in the centres of towns and cities, the headquarters are often far from the areas where the poor live and work, which is not so useful for the low-income market. For microinsurance, perhaps the most effective way of conveying this message is through branding – associating the insurer with something that is trusted by the poor. For example:

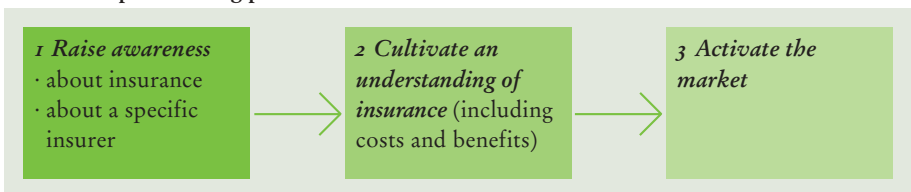
¹ This public sector scheme, Universal Health Insurance, has not reached as many people as expected, but it is not possible to determine if the problem was the marketing campaign, the product design or the delivery mechanism, or a combination of the three. The product is even cheaper for families living below the poverty line, who receive an annual subsidy from the central government of Rs. 200 (US\$4.60) for an individual, up to Rs. 400 (US\$9.10) for a family of seven. At the end of March 2004, 417,000 families were covered (Radermacher et al., 2005b).

- The logo of TUW SKOK (Poland) resembles the logos of the credit unions with which it works, to draw a connection between the trust that the members have in their credit unions and the credit unions' insurance company.
- SEWA has a powerful and trusted image among women in the informal economy that has significantly helped VimoSEWA. Even after difficult periods, such as the Gujarat earthquake when there was a surge of claims that exceeded the microinsurer's capacity and claims payments took three months or more, members gave VimoSEWA a degree of leeway that would not have been extended to most organizations.
- When AIG entered the Indian market, it was fortunate to start a joint venture with the Tata group of companies, one of the most respected and trusted Indian industrial conglomerates. When Tata-AIG entered the low-income market, it exploited the Tata brand: agents selling microinsurance assured potential clients that such a large company would have little interest in stealing their miniscule (in relative terms) premiums. In addition, it collaborated with local NGOs that helped strengthen its local credibility.

2 Marketing techniques

To convey these messages, microinsurers use a variety of marketing techniques. To get customers to the point of signing their contracts and paying their premiums, marketing managers have to go through three phases (*Figure 13*). First, they have to raise awareness about microinsurance and microinsurance providers. Second, they have to help the market understand the products, including the costs and benefits. Lastly, they have to activate the market by turning the increased awareness and understanding into a sale.

Figure 13 Three-step marketing process



2.1 Raise awareness

Raising the customer's awareness of insurance has two aspects: a) a general knowledge of insurance and b) specific familiarity with an insurance provider. From the experiences of microinsurers, the general receives far less attention than the specific. Few microinsurers use social marketing techniques to:

- educate their clients more broadly about insurance,
- describe how it fits into a broader array of risk-management mechanisms and
- illustrate the advantages and disadvantages of insurance relative to other ways of managing risk (e.g. savings or credit).

The only example of creating general awareness that emerged from the case studies was Tata-AIG, which produced brochures explaining insurance without actually mentioning the insurer or its product. The literature was disseminated by its NGO partners, and their credibility in the low-income market helped raised the standing of insurance as a viable intervention for the poor. (Obviously, the success of this approach may be constrained by the literacy levels of potential policyholders.)

There are two reasons why creating general awareness is not more common in microinsurance. First, for mainstream insurance providers, it is in their interest for clients to understand their products, but to have little knowledge about the industry in general. Second, general insurance awareness campaigns could equally benefit other insurance providers, so individual insurers will be less likely to undertake such an initiative. Indeed, since general awareness is a public good, the government or an industry association might be better positioned to engage in education campaigns, which is the case in South Africa (*see Box 30*). This is an area where donors might also be able to make useful contributions.

Box 30

Creating awareness: The experience of the South African Insurance Association

Under an industry charter, South African insurers have agreed to allocate resources to delivering insurance products to low-income households. In addition, they contribute 0.2 per cent of net profits for use in financial education. Members of the South African Insurance Association (SAIA), providers of non-life and short-term insurance products, decided to collectively deliver a consumer education programme, which covers seven themes: money management, budgeting, debt, saving, banking, life and short-term insurance and consumer rights and responsibilities. To raise awareness, SAIA has initiated three activities:

1. Development of a teacher resource kit targeted at secondary-school students;
2. A one-day financial literacy workshop in rural areas. To date, 10,000 people have received the training;
3. Commuter Net: with 17.5 million people commuting daily, this population has been identified as a priority target group. Several initiatives have been introduced:
 - Television screens have been installed in taxi parks and feature TV spots on the seven themes;
 - Radio stations provide interactive education;
 - 25,000 cassettes featuring music and financial education messages have been distributed at taxi parks; and
 - Comic books on financial education have been distributed.

Source: Adapted from the SAIA website.

Raising awareness about specific microinsurance providers is more prevalent than the promotion of general insurance literacy. The three most common approaches are through branding, public relations and prevention campaigns:

- **Branding** is an effective way of acquainting a market with an organization. To promote their brand, microinsurers tend to use signboards, in front of their offices or on billboards, with recognizable colours and perhaps a symbol. Another component of the brand is the tagline used in marketing materials to convey a general message about the organization to clients and potential clients; for example, Delta's materials say, "Delta Life, Prosperous Life", and similarly Tata-AIG's tagline is "A New Look at Life". Simple branding that uses illustrations or pictures is an effective way to convey a marketing message to both literate and illiterate market segments.
- Most microinsurers are engaged in **public relations** in one way or another. The most common public relations activity for life insurers is to hold claims award ceremonies, where a beneficiary receives an insurance payout at a public event. Larger microinsurers are also engaged in corporate sponsorship. For example, TUW SKOK supports a youth football team and an annual children's painting and drawing competition, low-key events intended to promote TUW SKOK's image as a community-based institution. Spandana (India) uses some of the surplus generated from its insurance scheme to finance education bursaries. These types of programmes demonstrate the organizations' commitment to the community in a tangible way without the need for glossy brochures and handouts.
- As described in Chapter 3.9, **prevention campaigns** can also raise awareness about a microinsurer. Shepherd (India) runs cattle care camps, partly funded

through a surcharge on each insurance policy, to promote the proper maintenance of animals and to provide free immunization and deworming. These camps are for the general public, not just members. Besides preventing claims, the camps also serve as a marketing vehicle. Similarly, ServiPerú has mobile medical units that visit cooperatives and other affinity groups to provide free medical consultations. Alongside these mobile facilities, a kiosk promotes its insurance services. BRAC MHIB and Grameen Kalyan (GK), both in Bangladesh, participate in the government's immunization campaign. Health authorities provide vaccines free of charge and a small contribution to cover the cost of promoting the campaign. Such participation strengthens the microinsurers' own prevention programme and enhances their image.

Creating awareness in the community-based model (*Chapter 4.3*) is a bit different because the microinsurer is not just asking prospective clients to buy insurance, it is also asking them to participate in the design and management of the insurance scheme (*see Box 31*).

Box 31

UMSGF's three-tiered marketing strategy

With a community-based model, marketing involves more than just trying to persuade someone to sign a contract and pay a premium. It is necessary to work with the community to help them reach the conclusion that by working together they will be able to collectively solve individual problems. In the case of Guinea's USMGF, which promotes *mutuelles de santé*, the problem that they are trying to solve is the affordability of access to health care.

UMSGF uses a three-tiered marketing strategy to activate and engage the community in creating *mutuelles de santé* or MHOs:

The **first tier** is at the community level, where promoters give presentations about the problem and possible solutions, and try to stimulate interest in insurance. This level is akin to general awareness raising.

The **second tier** involves two group-level approaches, both of which aim to explain how health insurance works in a little more detail. With the first approach, the promoters meet existing groups – ROSCAs or tontines, religious associations, women's groups, business associations and so on – to see if they wish to form an MHO. With the second approach, promoters encourage individuals who want health insurance to create their own mutual group with others they trust. Where possible, the objective is to work with the community's social groups, whether pre-existing or organized around the *mutuelles de santé* activities. In this way, they build on an existing infrastructure and leadership.

The **third tier** is the individual households, beginning with those persons whom organizers have identified as opinion leaders. Some people are not

comfortable asking personal questions, for example about their particular health needs, in front of others. Therefore, organizers have to follow up the group meetings with household-level discussions. Once they have been able to acquire a few influential converts, the promoters can then also involve these community leaders in persuading their neighbours to participate in the scheme.

Source: Adapted from Galland, 2005a.

2.2 Increase understanding

When the market has a general awareness of insurance and is familiar with the insurance provider, the next step in the marketing process is to increase its understanding of the specific products available, including product features and the costs and benefits of insurance relative to other risk-management strategies. This requires insurance education, which is particularly challenging in markets with low literacy levels.

Ultimately, one would hope that education would lead to shifts in knowledge, skills and attitudes, and in turn the adoption of microinsurance by the target market. Unfortunately, microinsurance providers tend to limit themselves primarily to information provision rather than education. There are, however, some notable exceptions. BRAC has pioneered the use of **street theatre** to educate target groups on the benefits of health microinsurance. Since 1998, BRAC's Social Development Programme has produced plays to highlight unjust, illicit and exploitative practices in society while preserving Bangladesh's rich tradition of local drama and folk songs. Participants are selected from among the MFI's clients and are provided with 10 days of intensive training in rural theatre. During the last three days of training, participants visit different villages to collect real-life stories reflecting critical social issues. Such methods promote the health insurance scheme by portraying the benefits if struck by a health problem.

A modern version of the popular theatre is the **video**, used by organizations like Tata-AIG to help potential customers understand how insurance works and why they should buy it. Unlike the street theatre, the video approach does not have the advantage of involving participants in the process of delivering the message, but in India Bollywood-style films can have a powerful impact on the target audience. Tata-AIG shows the videos from branded vans, and then once the film is over, the micro-agents can answer questions and sign up policyholders.

Low-tech education strategies can also be effective if they take into account the target market's education level. Perhaps one of the more com-

mon marketing techniques is the use of **pictorial presentations** – used by BRAC MHIB, AssEF and others – to illustrate how insurance works. An illustrated flipchart is a visual aid that helps to standardize the delivery of the main messages and increases the likelihood that audience will understand those messages. Yet the approach is still interactive and allows prospective policyholders to ask questions.

Literacy levels in a given community should influence the design of an educational campaign. In defining the depth and breadth of its market, a microinsurer must consider whether or not prospective clients are illiterate. If this is the case, microinsurers must provide the necessary information, about microinsurance in general and about the particular products being offered, without relying heavily on written communication.

One of the challenges when using any of these education techniques is to ensure that people actually understand and remember the main messages being conveyed. To address this challenge in Viet Nam, the Ninh Phuoc scheme has turned the exercise into a game. Key questions are written inside paper flowers, which are then placed in a tree or bush. Clients take turns picking the flowers and trying to answer the questions. If they get them right, the clients get a sweet or some other reward.²

When designing an education campaign, it is important to consider the market's heterogeneity. Different communication methods and messages may be required for each prospective market segment – a lesson learned by CETZAM (*see Box 32*). It is also important to define terms and avoid jargon. For example, in Uganda, the word “beneficiary” is associated with one who benefits from a social programme. Thus, clients frequently consider themselves as beneficiaries of their MFIs. Since there has not been adequate training, neither clients nor loan officers understand what this word means in the context of insurance.

Box 32

Regional differences in Zambia

In September 2002, CETZAM conducted market research to gauge its clients' reaction to the new life microinsurance product, *Ntula*. The research demonstrated that 81 per cent of clients thought that *Ntula* helped protect them and their business at a time of stress. The research also highlighted the reason for the demand for insurance: 41 per cent of clients reported a death in their family during the previous year. Interestingly, 15 per cent of CETZAM's clients were opposed to the introduction of *Ntula* and nearly all of these were located in Livingstone, a town in southern Zambia.

² This information about Ninh Phuoc was provided by Nguyen Thi Bich Van of the ILO office in Hanoi.

CETZAM's head office and the majority of its clients are based in the northern towns of the Copperbelt. It is common for clients to travel between these towns. As a common language is spoken, clients in other northern towns heard about the insurance pilot that was being conducted in Kitwe via the community radio stations. By the time *Ntula* was rolled out to the other Copperbelt towns, clients were already asking their loan officers for the product and as a result, its introduction was enthusiastically received.

By contrast, Livingstone in the south is a day's drive from Kitwe with a different local dialect and culture. "*Ntula*", which means "lifting up the burden" in Bemba, does not mean anything to the people in Livingstone. The clients and staff in Livingstone had not been informed about *Ntula* and so its introduction was met with resistance and suspicion.

It was later revealed that at the time of *Ntula*'s introduction, two other factors conspired to discourage Livingstone clients. First, loan disbursements had been recently delayed, which led clients to become concerned about CETZAM's financial health. The introduction of the insurance product, which was compulsory and involved a deduction from the loan, struck clients as a desperate measure to ensure the survival of the organization. They did not consider that *Ntula* would ever pay claims, and rather saw it as a levy on the loan to keep CETZAM running. Secondly, at the time of its introduction, a local newspaper was exposing incidents of "black magic" in the town. Clients linked *Ntula*, a product covering the death of the client plus five family members (six people in all), as being somehow demonic. It took several weeks of street theatre by a local organization to change public perception of insurance in Livingstone.

Source: Adapted from Leftley, 2005.

When developing insurance education tools, it is also useful to consider the diverse **array of potential communicators**. Many microinsurers team up with other organizations (or other parts of their own organization), including healthcare workers, social workers and government officials, to communicate with many prospective policyholders. For example, GK in Bangladesh uses the maternal and child health services provided to poor households by the roving health assistants of a sister organization as a promotional tool. Similarly, BRAC's non-formal education teachers promote the health insurance scheme to parents of their students. Mutual and cooperative insurers use their affinity groups, which often have education committees, as a key means of promoting insurance education. In general, for these "insurance educators" to be effective, they need sufficient tools and training to deliver the messages.

One of the strongest lessons that emerged from the case studies is that it is much easier to communicate with clients if the product is kept simple. La Equidad in Colombia has two microinsurance products and has had greater success with the simpler of the two. As described in Chapter 3.1, it is easier for clients to understand the product if there are no exclusions, if the benefits are uniform or at least straightforward, and if the pricing is transparent. Ideally, it should be possible to explain the details of the product in five minutes or less.

Where products are complex, field staff often explain just a fraction of the benefits, exclusions and procedures. If staff do not mention certain benefits, then clients will not claim those benefits if the insured event occurs. If staff do not explain the procedures, then the process of making claims is also likely to be extremely inefficient for all involved.

A major obstacle to increasing the market's understanding of the insurance product is the fact that many people in the distribution system do not understand it. This staff problem, common among microinsurers, emerges for several reasons, including a lack of good staff training, insufficient monitoring and incentives for staff and high salesperson turnover. This challenge, which few organizations have succeeded in overcoming, is discussed in Chapter 3.7.

2.3 Activate the customer

Once the market is aware of insurance and the insurer, and it has an understanding of the product, the third phase in the marketing process is to arrange for the customers to sign their contracts and pay their premiums.

One approach to activating the customer is through annual subscription periods or **enrolment campaigns**, such as those used by VimoSEWA and UMSGF. As summarized in Table 22, there are advantages to both annual campaigns and rolling admissions. Annual campaigns can motivate staff for one big push to sign up customers. It activates some lukewarm or undecided persons to buy insurance because they do not want to wait another whole year before receiving cover. In addition, once-a-year enrolment provides some underwriting control, since policyholders could not choose to enrol only when they became ill; they can only sign up during the campaign. A key disadvantage is that it creates a peak workload period for staff. Furthermore, members missing the campaign have to wait a year to get insurance. The campaign also has to be timed so that policyholders have a year's worth of premiums available during the enrolment period – as Karuna Trust learned (*see Chapter 3.3*).

Table 22

Rolling admission versus annual campaign

<i>Advantages of rolling admissions</i>	<i>Advantages of an annual campaign</i>
Workload is more evenly distributed throughout the year	Helps to control adverse selection because members cannot choose when to join
The scheme can always add new clients	Focuses marketing attention in a concentrated period
Different market segments may need to pay at different times during the year	May activate some clients

Other promotional activities include raffles or lotteries. For example, Columna periodically organizes raffles in which policyholders can win household appliances. Such an approach can be designed to benefit the policyholders, the sales agents, or both.

One activation strategy that microinsurers should avoid was tried by Delta Life. In the 1990s, it introduced a complementary product whereby policyholders could get a microenterprise loan. Indeed, a key reason for Delta's exponential growth during this period was that agents used the prospect of getting a loan as an enticement to start an insurance policy. This offer was quite attractive because one could get a Tk. 5,000 (US\$83) loan after paying a few hundred *takas* in premiums. However, many of these policies lapsed, and many loans were not repaid (*see Box 37 in Chapter 3.3*).

Regardless of whether marketing is stimulated by an annual campaign, raffles or other sales gimmicks, ultimately the most important factor in selling voluntary insurance is the agent's technique, the persuasiveness of the personal sales pitch and word of mouth from their peers who have had a good experience by having a microinsurance policy. Unfortunately, microinsurers are generally lacking in this area. Since they tend to rely on low-cost or even volunteer promoters, or on salespersons who distribute insurance in addition to their main activity (e.g. savings and loans), there is significant room for improvement, as illustrated in Box 33.

Box 33

Sales challenges at T UW SKOK

T UW SKOK's sole *raison d'être* is to serve the credit unions and their members. Yet the nature of that relationship creates a dynamic tension that must be carefully balanced. The success of the insurer depends entirely on the success of its distribution system, the credit unions – their ability to grow, the ability of their staff to sell insurance products and the willingness of CU managers to promote insurance sales. This arrangement creates challenges relating to the quality of the sales force, their commitment and motivation to sell and their availability for training.

The insurer recognizes that it is easier for CUs and their part-time insurance agents to sell insurance that is linked with savings or credit products than stand-alone insurance policies. If someone wants a contractual savings product, for example, then it is quite natural to ask them if they would like the inexpensive savings completion insurance in the event of accidental death or disability. It is much harder to sell a tenant's insurance product that has no link to either savings or credit.

For the member-pay products, the credit union and the insurer could be competing for the member's finite financial resources.³ The only way they can both succeed is if they can increase the amount of money that the consumer is willing (and able) to spend on both.

To overcome some of these challenges, TUW SKOK invests time and money in cultivating a good relationship with the CUs, with a strong emphasis on communication and information-sharing. Twice a year, the insurer holds a retreat with the managers of the major credit unions, and uses that opportunity to inform the CUs of upcoming plans, to solicit feedback on product design and customer service, and to cultivate sales competition between credit unions.

Source: Adapted from Churchill and Pepler, 2004.

Early on in its relationship with AIG, FINCA Uganda recognized that its staff had limited sales skills, so it organized marketing training by a professor from Makerere University. These new sales skills led to significant improvements in growth, from a 5 per cent participation rate to over 40 per cent the year after the training. Later, however, the insurance product became mandatory for borrowers, after which all selling ceased and even information dissemination was neglected (McCord et al., 2000).

Microinsurance requires a different sales culture from conventional insurance. Instead of telling people about the product and its benefits, agents need to guide prospective clients towards the conclusion that emergencies are expensive and that they are vulnerable to emergencies by asking about their experiences or the experiences of their neighbours. They act as advisors instead of salespersons, helping low-income households to recognize what risks it would be appropriate to manage through insurance. In general, because of the target market's lower literacy levels and lack of confidence in formal insurance, microinsurance agents are required to be hands-on and personally involved.

³ As discussed in Chapter 4.1, in the cooperative-network model, it is important to distinguish between insurance purchased by the credit union or SACCO as a member benefit, like loan protection and life savings, and those insurance products for which the members pay, like life insurance.

To activate the customer, microinsurance marketing has to activate the seller, and this is where things get a little sensitive. Microinsurers want to reward and encourage sales without pushing insurance onto people who do not really want it. Finding this balance is difficult and can represent a slippery slope. Microinsurers who claim to operate in the best interests of the client must actually do so. For example, although the insurance provided by ASA (India) is nominally voluntary, in practice, the scheme has the same number of borrowers as policyholders. Members feel obliged to buy insurance, as they think they may otherwise not receive the loan (which is what they really want). Some strategies to find this balance include:

- **Setting moderate sales targets** that can be achieved without aggressive measures. If microinsurers try to push agents to achieve large volumes, they might have to resort to sales techniques that are not in keeping with the spirit of microinsurance.
- **Balancing sales commissions with re-enrolment incentives** to ensure that service gets the same attention as sales.
- In commercial insurance companies, **setting up a separate operational department** for microinsurance so that it can develop a unique sales culture.
- **Encouraging the sales people to buy insurance** as well, so they can speak from experience.

Delta Life has learned a few things about which sales incentives are worth avoiding. Initially, it front-loaded commissions for new policies, which encouraged some agents to use part of their commission as an unofficial first year discount. Agents were paying a portion of the first year's premiums out of their own pockets, and when policyholders had to pay the full premium themselves, many policies lapsed. Another misplaced incentive scheme provided a crockery set to agents who sold a certain number of new policies, only to find that agents teamed up and submitted contracts under one agent's name, and then shared the dishes.

Of course, all of these marketing strategies come at a cost. Some microinsurers see marketing as an expense rather than an investment, and are therefore reluctant to commit enough money to promoting their schemes. There is also a problem at the other extreme, particularly with commercial insurers that pay overly generous commissions.⁴ However, how much is enough, and how much is too much? The amount varies by product line, the maturity of the scheme and the institutional model, from a low of 2 per cent to as much

⁴ For example, McCord et al. (2005a) estimates that one of AIG Uganda's sales agents earned US\$158,000 in commission in 2004 (i.e. 20 per cent of the premiums paid by the MFIs to the insurer).

as 40 per cent of premiums. Individual products require greater marketing investments, especially when taking into consideration the field agents' commissions. For group business, marketing expenses should be much lower. As a general rule, marketing expenses for group microinsurance products (including commission) should be in the range of 5 to 15 per cent of premiums.

Overall, however, marketing is not one of the strengths of most microinsurers. Yet given the reluctance of the market to accept insurance, greater attention, creativity and resources are required.

3 After-sales service

One way that microinsurance demonstrates its uniqueness in relation to conventional insurance is by de-emphasizing sales and emphasizing service. Service in insurance parlance is largely linked to claims: making sure clients know how to make claims, assisting them in meeting the documentation requirements, and ensuring that claims are paid quickly with a bare minimum of rejections. In addition, continuous reminders about the product may be necessary to ensure that an illiterate market does not lose sight of its insurance coverage.

This emphasis on after-sales service is necessary. It can be seen as an extension of an on-going process of building trust between the insurer and the policyholder. Furthermore, for schemes that have already invested so much in its customers, through awareness-raising, education and so on, it is extremely inefficient to then lose those customers due to poor service. Excellent service creates a **demonstration effect** whereby the non-insured begin to see that the insurer means business, that it is fulfilling its obligations, that it is trustworthy. Excellent service can be a marketing strategy as well, since it stimulates positive word-of-mouth advertising, which is often one of the most powerful marketing channels.

Given the importance of after-sales service, one of the shocking deficiencies of many microinsurance schemes is that the client often does not receive a **policy document** that explains the benefits, exclusions and claims procedures.⁵ Such information, and an accompanying explanation, is necessary to reduce rejected claims. When policyholders understand what is and is not covered, they are less likely to submit claims for losses that are not covered.

⁵ One explanation for the lack of written material is the fact that the target market is often illiterate. However, in most markets, illiterate adults usually know someone who can read, often someone in their own household. Another explanation is that in some cultures, like parts of India, people do not trust written information. More realistically, however, the main reasons are: 1) not wanting to invest in printing costs and 2) not wanting to be tied down to specific terms and conditions, neither of which seems particularly justifiable.

VimoSEWA had the opposite problem. After several years of surprisingly low claims rates, it realized that many policyholders were eligible to make claims but did not submit them. Consequently, in 2003, VimoSEWA initiated a strong after-sales service campaign. Now *Vimo Aagewans* establish contact with members between enrolment periods to re-explain coverage, ask if they have been hospitalized and assist in claims submission. Policyholders receive a poster to hang on the wall as a reminder of their membership, which contains the name of their sales agent and the office's address and phone number to make it easy for the member to ask for assistance. In addition, all members are given a pre-stamped and pre-addressed postcard, which they can mail to the office if they need an *Aagewan* to visit them. VimoSEWA expects that these measures will make it easier for members, particularly poorer ones, to submit claims. Because of these interventions, current renewal rates are now at an all time high.

Despite efforts to educate clients and ensure that they understand the benefits and the claims process, there will invariably be some claims that have to be rejected. The microinsurer (or its distribution agent) has another important after-sales responsibility to convey to the insured – and perhaps to other community members as well – why the claim was rejected in such a way as to lessen the negative impact of the rejection and to turn a potential public relations nightmare into an education opportunity. For example, to lessen the impact of a rejected claim, VimoSEWA has improved its communication to members and the community through visits from the *Vimo Aagewan* accompanied by head office staff members.

Furthermore, a **claims appeal process** is needed to ensure that policyholders receive appropriate treatment, although in practice few microinsurers have such an arrangement. TUW SKOK is an exception. In its clearly defined claims appeal process, a member who is dissatisfied with the adjudicator's determination may appeal the claim in writing. All appeals are reported to TUW SKOK's board for consideration. Reversals or modifications to benefits usually occur with disability claims, for example if the policyholder submits supplementary medical information leading to an increase in benefit.

The final aspect of after-sales service is **measuring customer satisfaction** and monitoring retention. Microinsurers generally make a better job of the latter than the former, although measuring retention is tricky with mandatory insurance since the organization does not know how insurance is (or is not) contributing to desertion. In general, there is a greater need to understand why policyholders are not renewing their cover.

4 Marketing and mandatory insurance

An interesting marketing challenge emerges in organizations where insurance is compulsory. As described in Chapter 3.1, there are many advantages to mandatory insurance for insurer and policyholder alike, but to fully appreciate those advantages, microinsurance schemes need to compensate for the equally glaring disadvantages, especially the marketing problem.

When insurance is mandatory, there are essentially no sales activities involved. Someone gets insurance cover automatically because she or he has obtained something else, perhaps a loan, or opened a savings account. Consequently, the distribution agents tend to overlook the clients' need for information. From research among MFI clients with compulsory cover in Uganda (McCord et al., 2005a) and Zambia (Manje, 2005), a number of common problems emerge:

- Clients do not know they have insurance
- If they do know, they may not be aware of all of the benefits
- They may not know how to make a claim
- They consider compulsory insurance as a cost of getting a loan
- They do not know how much they pay for insurance because premiums may be deducted from the loan or combined with other fees – most think they pay more than they really do
- Some feel that they deserve a premium refund if they do not make a claim

To overcome these perception problems, the distribution agents have to treat insurance as a *complementary* service and persuade clients of its usefulness. Marketing for mandatory insurance essentially focuses on increasing the membership or consumption for whatever is the driver to which insurance is linked, such as a loan, credit union membership or employment. In this context, insurance needs to be presented as a valuable, additional benefit, not a cost.

Product information provided to clients should be standardized and simplified to avoid claim rejections resulting from misinformation. As a minimum, organizations should provide a simple brochure for each client showing the breakdown of fees and benefits, and describing the claim settlement process. According to Manje (2005), even though the products are mandatory, there are several opportunities for insurance marketing, such as:

1. Including some voluntary components in the insurance policies, such as additional lives for funeral insurance, to increase the likelihood that staff will explain the options to clients.

2. Highlighting the menu of financial services with prices to market mandatory insurance in a full package of services, not as a condition for getting a loan.
3. Showing clients how much they would have to pay for the same cover if they bought it on their own. Since individual insurance products are often several times more expensive than group policies, this is an important selling feature to persuade people that they are getting a great deal from the mandatory group policy.
4. Making the product real. Use testimonials from beneficiaries who have received settlements to communicate the importance of receiving that settlement when the family needs it most.
5. Promoting the solidarity nature of insurance so that people do not feel that they have wasted their money if they do not make claims.

With a mandatory product, it is rather difficult to gain a firm understanding of the true demand for microinsurance. CARD has made an effort to understand this demand and how it affects its business. In a qualitative survey conducted by Freedom from Hunger, many clients identified insurance as the most valuable aspect of the entire CARD product portfolio. Such a finding should inspire other microinsurers to market their mandatory insurance products in such a way that clients will actually appreciate it.

5

Conclusion

By way of conclusion, this chapter provides a checklist of questions (*see Table 23*) that may help microinsurers to assess and improve their marketing strategies.

Table 23

Marketing checklist for microinsurance managers

- Who are you trying to communicate with? What are effective ways of reaching that audience?
- What is the education and literacy level of your target audience? How will you incorporate this into your marketing plan?
- What is the clients' need for risk coverage? How is this being addressed? What is the benefit of the product?
- What are the anti-insurance arguments of the target market? What main messages would counter those arguments?
- What can you do to strengthen the market's trust in your organization?
- How can you convey the risk-pooling or solidarity message so that policyholders who do not experience an insured event do not expect their money back?

- How can the product be depicted in a positive light?
- What type of prevention campaigns and other public relations activities would have the greatest impact in raising awareness of your organization?
- How can your organization move beyond information and communication to include education about insurance?
- Do you have methods to assess whether your customers or the market really understand the main messages that you are trying to convey?
- What possible partners can be involved to assist in the education and promotion activities? What tools and training will they require to fulfil that function?
- Is the product and claims process sufficiently simple for salespersons to explain it to potential clients?
- What marketing techniques are likely to be most successful in attracting clients (e.g. enrolment campaigns, raffles)?
- What incentives will effectively motivate salespersons while cultivating an appropriate microinsurance sales culture?
- How can you encourage or solicit word-of-mouth marketing?
- How can you ensure that clients perceive that you are providing outstanding customer service?
- Are you monitoring customer satisfaction and retention?
- How can you persuade customers to appreciate the benefits of mandatory insurance?

3.3 Premium collection: Minimizing transaction costs and maximizing customer service

Michael J. McCord, Grzegorz Buczkowski and Priyanka Saxena¹

The authors would like to acknowledge the contributions to this chapter from Aristotle Alip (CARD) and Ellis Wohlner (consultant to SIDA).

When extending insurance to the low-income market, the process of collecting premiums is a major challenge. The target market is largely self-employed or works in the informal economy, and is unlikely to have a savings account with a bank. Consequently, the primary premium-collection mechanisms used by mainstream insurers – salary deductions from employers and standing orders or direct debits from savings accounts – will not work for many poor households. To compound the matter, by definition the target market has low, often irregular and unpredictable incomes, so another challenge is to schedule the premium payment for a time when the policyholder has funds available.

For microinsurance to succeed, the premium payment mechanism needs to find a balance between being efficient and being sensitive to the needs and capacities of clients. Simply collecting a large number of small premium payments may make the products more accessible to the poor, but can also result in higher transaction costs that drive up premium rates.

Based on a review of the case studies, this chapter proposes possible solutions to these problems, organized around the following four topics:

1. Modes of premium collection
2. Collection frequency and timing
3. Client considerations
4. Premium collection controls

I Modes of premium collection

The way in which premiums are collected has a direct bearing on per unit transaction costs. Indeed, to make microinsurance viable, it is necessary to minimize transaction costs. Undoubtedly, however, the key factor in decid-

¹ References to Microcare (Uganda) in this chapter are drawn from the authors' experiences.

ing on the mode of premium collection is still the clients' circumstances and access to other financial services. This section describes four modes of premium collection.

1.1 Premiums linked to loans

Many types of microinsurance products are linked to other financial products, especially credit. Premium collection at the point of loan disbursement or repayment is attractive since the transaction is “piggybacked” on top of another financial transaction. Consequently, the marginal cost of premium collection is kept to a minimum.

This can be demonstrated by comparing the premium collection costs of stand-alone insurance with cover combined with another financial service, such as loans. For its stand-alone tenant's cover, for example, TUW SKOK (Poland) pays the handling agent market rate commissions of, on average, 15 per cent. For integrated products such as its loan-linked AD&D coverage, the insurer incurs a total cost of less than 1 per cent of premium. TUW SKOK's systems have been developed to manage monthly premium collection from loan add-on products for over 200,000 insureds, and from more than 60 credit unions nationwide, handled by three staff members at the insurer's headquarters.

Linking insurance to loans is the mode of collection employed by many MFIs. Some clients, like those of Pulse in Zambia, are content with this method because they “don't feel the pinch”. In addition, as described in the previous chapter, the insurance cover can be marketed as a benefit of getting a loan. For other clients, this linkage can be a major cause of dissatisfaction. With CETZAM's funeral insurance product in Zambia, for example, clients complained that the deduction of the premium from the loan reduced the amount of cash that they received. The actual premium payment mechanisms vary, as described in Box 34.

Box 34

Linking insurance premiums to loans

Many MFIs offer insurance by linking it to their loan products. There are, however, several different ways in which the premium can actually be paid, all of which have advantages and disadvantages. The five general alternatives are:

1. Deducting the premium from the loan amount

This is perhaps the most common approach, but borrowers generally do not appreciate the fact that, for example, they apply for a US\$400 loan and only get US\$390 after the US\$10 premium has been deducted. In addition,

borrowers pay interest on the premium amount, which increases the gross cost of the insurance.

2. Adding the premium to the loan amount

Another approach is to grant a loan of, for example, US\$400, but to oblige the client to repay a total amount of US\$410 plus interest. In this way, the client at least receives the expected sum, but still pays interest on the premium amount.

3. Building the premium into the loan interest rate

Some organizations increase their interest rate slightly, and use the additional revenue to pay the premium on behalf of the clients. Of the five options, this is probably the least advantageous because: a) it makes the interest rate appear less competitive and b) it disguises the premium so that borrowers may not realize that they have insurance coverage. However, this method is by far the simplest of the loan-linked premium payment methods since it is just an internal accounting transaction.

4. Paying the premium with each loan instalment

To make the premium more affordable, the amount can also be divided up and paid in instalments with each repayment. However, this approach shares some of the disadvantages of combining interest and premium rates: clients may not know they have insurance and the MFI probably has to pay the insurer in advance. Additionally, will the coverage be cancelled if the client falls behind with loan repayments?

5. Paying in cash up front

If borrowers pay the premium up front, either when they apply for the loan or when they receive it, there is a greater likelihood that they will be aware that they have insurance. However, compared with options 1 and 2, this creates an additional transaction and increases vulnerability to fraud as cash changes hands.

The most notable disadvantages in using this mode of collection are:

1. Lack of transparency

The same reasons that make Pulse's clients "not feel the pinch" may also mean that clients are not aware of the actual price they are paying for the benefits. Interestingly, in Zambia, many clients assumed that they were paying more for insurance coverage than they actually were (Manje, 2005).

2. *Unaware of cover*

Even worse, clients (or beneficiaries) may not know that they have insurance, so they may not receive the benefits that are due. This situation undermines one of the important development objectives of microinsurance that is to create an insurance culture in which the low-income market develops an understanding of and appreciation for the risk-management role of insurance.

3. *Protection limited to loan term*

This payment mechanism means that the target market can only receive insurance protection when they have a loan. While they might require continuing cover, most people, rich or poor, prefer not to be perpetually in debt.

In response to this last problem, members of the credit unions associated with Columba (Guatemala) can renew their insurance policy without borrowing again. However, because the initial distribution system is linked to credit, it is difficult to get the credit union staff to renew the policy because it is no longer related to their core activities. Indeed, in the Philippines, CARD MBA and CARD Bank have been in dispute because the insurer wishes to continue coverage when borrowers are no longer borrowing from the bank. The bank argues that this eliminates an incentive for people to continue borrowing.

Finally, loan-linked insurance premiums are certainly appropriate for coverage that directly enhances the security of the loan for both the borrower and the lender. Credit life and property insurance for collateral are products which lend themselves to being linked. Other products may not be as appropriate, such as family life cover or health covers. Such products cannot generally be part of mandatory loan-linked cover since they are relatively expensive and do not have a direct connection to the loan.

1.2 **Automation: Deducting premiums from savings accounts**

Where possible, automatic premium collection is advantageous in reducing transaction costs. For TUW SKOK, since all its low-income policyholders have savings accounts, the credit union can easily deduct the premiums from the members' accounts and forward them to the insurer, with hundreds of small premiums batched into one electronic transfer. Standing orders/direct debits lower transaction costs and minimize vulnerability to fraud.

The main disadvantage of automatic payments is that the target market may not have a savings account, or even the possibility of opening one. Indeed, to expand the availability of microinsurance to more low-income households, a key strategy is to increase their access to savings services.

However, some microinsurers have this option available to them and they are not taking advantage of it. For example, ALMAO in Sri Lanka was started by the savings and credit societies of the Sanasa movement. Yet, despite the 2 million Sanasa members, ALMAO only has a few thousand policies, in part because it is relying on door-to-door collection rather than standing orders.²

This premium collection mode is vulnerable to public relations problems if not properly implemented. VimoSEWA (India) experienced significant difficulties when it used automatic payments for its then mandatory insurance scheme because it had not adequately informed savers that the payment would be deducted from their accounts. Consequently, the organization experienced a significant backlash from policyholders and ultimately had to change to voluntary coverage.

1.3 Premiums paid from savings account interest

Perhaps the simplest mode of collection is to allow premiums to be paid from the interest on a savings account. The most common example of this approach is the life savings product offered by many credit union insurers, as described in Chapter 2.3.

Similarly, policyholders at VimoSEWA – which has tested many different premium payment mechanisms – can make a deposit into a special SEWA bank account, and instead of earning interest, they receive “semi-permanent” insurance coverage until they reach the age of 60 without any additional transactions. Consequently, the depositor never pays any premiums and still has access to and ownership of the money in the savings account. In a sense, this is like pre-funding a whole life policy. Yet, since the money is still theirs, it helps overcome one of the complaints about insurance from the poor, which is, if they do not make any claims, they feel they have wasted their money paying premiums.

This fixed deposit payment approach undoubtedly minimizes transaction costs. However, it may also be limited in its penetration if the amounts required from clients are too high. At ASA in India, which also experimented with this payment method, not enough of its members could come up with the funds to justify continuing this mechanism. In VimoSEWA’s case, if a member is just insuring herself, she needs to make a fixed deposit of Rs. 2,100 (US\$46) or she could pay an annual premium of Rs. 100 (US\$2.20). Even though a quarter of its members use the fixed deposit approach, the propor-

² At its peak, ALMAO’s unregulated predecessor provided funeral insurance to nearly 50,000 persons, but its new endowment products have not been particularly popular.

tion has declined over the years (down from 33 per cent in the case study (Garand, 2005)).

This fixed deposit approach works better in a high-interest environment, and is vulnerable to interest rate decreases which may lead to a situation where interest is not sufficient to cover the cost of insurance. In such a situation, as well as when premium rates are adjusted upwards, VimoSEWA has found that it is difficult to get depositors to top up the savings account. When it is topped up, the cost to the depositor is dramatically greater than the amount of the premium increase. For example, if the interest rate is 10 per cent and the increase in premium is Rs. 10 (US\$0.22), the top-up amount must be at least Rs. 100 (US\$2.20) to cover the increase.

1.4 Physical premium collection

The fourth approach is to physically collect the premiums, either by going door-to-door to collect individual payments, or through group mechanisms where many premiums can be collected at once, or by requesting policyholders to come to a central location to pay their premiums. A key distinction between this method and those discussed above is that it is an insurance-only transaction, whereas the other modes are all linked to either a savings or a credit product. Consequently, physical premium collection is most appropriate for: a) organizations without other financial transactions such as community-based health insurance schemes (*see Chapter 4.3*) and b) accumulating-value policies that are difficult to combine with other financial services (*see Chapter 2.2*).

This physical collection method has the advantage of being accessible to clients while providing opportunities for personal interaction between the insurer and its customers. For example, in Bangladesh, Delta Life's door-to-door collection gives clients a physical link with the company, while potentially reducing lapses (although they are still a significant problem) and strengthening the relationship between field staff and the customer. In addition, women in some households are discouraged or prevented from travelling, so door-to-door collection also provides them with access to a valuable service.

The most apparent deficiency of physical premium collection is the insurer's transaction costs – door-to-door premium collection is expensive. Compensation for employees must be aligned with their perceptions of the effort involved. If staff are not motivated to collect premiums, schemes will undoubtedly fail. For example, La Equidad experienced collection problems when it experimented with door-to-door collection because the small commissions were insufficient to motivate its sales force.

Requesting individual low-income policyholders to come to a central location to make premium payments is not a practical solution unless they are already coming to perform another transaction. People are naturally averse to spending time and money to make such a payment, especially within a dictated period.

The possibility of fraud also increases dramatically through this mode of collection because of the number of people handling the premiums. A dangerous aspect of door-to-door collection is that in many legal systems, once the premium is collected by an agent or representative of the insurer, it is legally considered collected by the insurer, entitling the insured to coverage even if the agent does not transfer the premium to the insurer. If not detected early, this may lead to significant financial losses, as claims would have to be paid even though the insurer had never received premiums. In many jurisdictions, it is very difficult and expensive to recover premiums from those guilty of fraud, even if they are identified and caught.

Fraud in premium collection will not only cause financial deficits, but will also make clients wary of insurance, perhaps reinforcing the market's negative preconceptions. In one of the mutual health organizations linked to UMSGF in Guinea, group leaders misappropriated premiums collected from households. The members have lost confidence in the MHO, which is having difficulty overcoming the crisis. Mitigating such fraud requires strong controls that in turn lead to more expense.

1.5

Conclusion

A comparison of these four approaches, summarized in Table 24, has to consider the cost-effectiveness of the mechanism in relation to the value that is provided to policyholders (e.g. ease of access, understanding of the product, premium rate).

The difference in costs between maintaining a team of agents for door-to-door collection and using an intermediary entity can be substantial. Consider a comparison between Delta Life and AIG Uganda, which both serve a million or more customers. Delta employs its own agents to service policyholders on an individual basis, whereas AIG Uganda offers mostly mandatory group policies sold through 26 MFIs. The difference in operating costs between these two methods as a percentage of premiums is about 10 per cent, with the MFI agencies being significantly less expensive than an army of agents.

Door-to-door premium collection offers an opportunity to maintain a close relationship with the insured, which, if managed and exploited properly, may offer valuable information to the insurer, as well as help maintain

loyalty and keep lapse rates low. However, physical collection results in high costs because of the need to pay sales commissions out of very small premiums and the strong controls required to prevent fraud. The dangers of fraud must also not be underestimated, as they can destroy the crucial bonds of trust between the parties, and result in financial losses for the insurer. In general, it is best to stay away from physical collection if any alternative method is available, and to identify ways of collecting premiums from groups of policyholders.

Table 2.4 Comparison of premium collection modes

<i>Mode of collection</i>	<i>Enhancing value to clients</i>	<i>Minimizing transaction costs</i>
a) Linked to loan product	<ul style="list-style-type: none"> + Enhances affordability since borrowers can pay the premium when they get the loan (or spread payments over the term of the loan) – Can increase the cost of insurance through loan interest costs – Insurance coverage only available when a loan is outstanding (no access without a loan) 	<ul style="list-style-type: none"> + Minimal additional costs by piggybacking on existing transactions + Especially when mandatory cover allows for simple group coverage
b) Deducted from savings account	<ul style="list-style-type: none"> – Only available to persons with savings accounts + Eliminates indirect transaction costs to the policyholders 	<ul style="list-style-type: none"> + Only electronic transactions
c) Paid by savings interest	<ul style="list-style-type: none"> – Policyholder has to have enough money to fund fixed deposit account + Clients do not feel that premium payments are wasted + Provides semi-permanent coverage 	<ul style="list-style-type: none"> + As easy as savings account deduction – Notification and prompting required for increases – Not appropriate for low-interest environments
d) Physical collection	<ul style="list-style-type: none"> + Door-to-door collection means no opportunity costs for policyholders (do not need to miss work to pay the premium) + May enhance access for women who cannot travel – Large percentage of premiums goes to pay commissions and insurer's overheads 	<ul style="list-style-type: none"> – Very high transaction costs offsetting benefits of access – Cost of controls to limit fraud risk can be high

2 Collection frequency and timing

Besides the mode of collection, microinsurers also have to consider the frequency and timing of collection. As discussed in Chapter 3.5, insurers generally prefer to be paid in advance of policy activation so that they can generate additional income by investing the money, which in turn should lead to lower premium rates. For the low-income market, however, it may not be possible to pay premiums up front; it may be necessary to pay in smaller instalments over time. Similarly, it may be useful to allow for variability in clients' means by offering a flexible time frame in which premium payments can be made.

Periodic payments – monthly, quarterly or annually – are a popular mode of premium collection because they are inherently more attuned to the limited purchasing power and liquidity of the target market. The main disadvantages are the additional transaction costs (especially with more frequent payments) and the increased likelihood that the policyholder will choose to cancel the coverage – every possibility that clients have to renew their affiliation to a scheme is also an opportunity for clients to temporarily or permanently cease their membership.

One of the key lessons about collection frequency is that assumptions by microinsurance providers about clients' preferences and abilities to pay are not always valid. Delta Life started off with weekly payments in the 1980s, but experience over time led to a better appreciation of client preferences; today most policies are paid through monthly and quarterly payments. BRAC MHIB serves a particularly poor and financially vulnerable target market. As a result, it may seem obvious that payments should be as small as possible and thus collected frequently. However, BRAC MHIB's clients were unhappy with weekly premium collection because it was too burdensome to make savings contributions and loan repayments, and pay insurance premiums all at the same time.

The timing of premium collection is another critical factor. For example, BRAC MHIB learned that clients engaged in activities such as agriculture, fisheries and poultry, which generate income quarterly or semi-annually, preferred premium payments to coincide with their cash flow. Indeed, trying to collect premiums at an inconvenient time for clients can be futile. At the end of Karuna Trust's pilot phase, premiums were collected in June and July when there was unfortunately little employment for most daily labourers. Obviously, it was not appropriate to collect premiums at a time when many households barely had enough money for food. After further discussions with clients, Karuna realized that September to November would be a

better time for premium collection since they expected to have sufficient work then.

To probe the issue of timing a bit further, it is necessary to consider not just when the target market will have money, but where are they getting the money from. If many people receive money from the same source, it may be possible for that source to pay the premiums en masse for many policyholders and therefore enhance efficiency. This is the essence behind the loan-linked mechanism described above – people (usually) have money when they receive a loan. Are there other common providers of money that would allow the insurer to collect premiums at the source?

Another approach allows policyholders to make premium payments within a defined period, as opposed to a specific point in time, and is quite popular among informal funeral insurance providers in South Africa (*see Box 35*). Indeed, this approach tries to accommodate the variability in poor people's incomes and purchasing abilities. However, more administrative capacity is needed to monitor flexible payment systems, and transaction costs are higher if clients are allowed to modify their payment plans.

Box 35

Flexible premium payments for funeral insurance in South Africa

Funerals are a major life-cycle expense for low-income South Africans. In the Grahamstown township, low-income households spend approximately 15 times their average monthly household income on a funeral. A common means of funding them is through funeral insurance. A myriad of formal and informal insurers compete to sell coverage to the low-income market, including funeral parlours that provide a benefit in kind. Some of these informal funeral schemes have adopted an interesting flexible premium payment mechanism.

Households pursue multiple livelihood strategies, with incomes from a variety of sources at different times. They need to pay the premiums whenever they have money, not at a specific time during a month. As one informal insurer put it, “people here live a hand-to-mouth existence; you cannot expect them to pay at the same time each month”.

Therefore many informal insurers allow clients to pay premiums – including partial payments – by bringing whatever cash they have on hand to the funeral parlour, perhaps making multiple visits during the course of the month. When a premium is received, the client's booklet is stamped and dated. As long as they are up to date with their payments by the end of the month, then the policy remains in force (some schemes keep policies active as long as clients are not more than three months in arrears).

The use of booklets or coupons is attractive to both insurers and their clients. With this system, clients feel they have a secure document with which

they can prove premium payment. Such a system is comparatively cheap and easy for insurers to operate. In addition, payment flexibility is also beneficial since it helps adapt insurance products to poor clients' cash flows.

Source: Adapted from Roth, 2002.

Flexibility in the timing of premium payments is an important component of access to microinsurance; however, there are significant costs, including losses associated with greater exposure to staff fraud, involved in providing that flexibility. The ability to manage such flexibility requires information systems that can accommodate it without a major increase in costs. Otherwise, microinsurers cannot offer this level of access without significant pricing implications.

3 Client considerations

3.1 Financing insurance premiums

To expand the outreach of microinsurance and make existing schemes more viable, providers need to explore ways of assisting policyholders to finance their premiums. Indeed, for most low-income households, the problems encountered in affording premiums are not an absolute barrier to purchasing insurance. Rather, the problems arise because they do not have enough money at the right time – many poor households could afford premiums if they had access to suitable financing mechanisms. These mechanisms may enable microinsurance providers to expand their markets, and gain larger and more reliable client bases. Appropriate financing mechanisms also champion the social nature of microinsurance, as clients for whom insurance was previously unaffordable will be able to benefit from formal risk coverage.

One of the simplest ways of providing financing options is to work with self-help groups or rotating savings and credit associations. Insurers that are linked to SHGs or ROSCAs can encourage members to make small increases in their regular savings deposits so that when an annual premium comes due, the members already have the money. Through financing partnerships with ROSCAs, insurers benefit from existing informal savings mechanisms, while their members can amass the insurance premiums without additional transaction costs.

Working with cooperatives may provide similar benefits. Customized options for financing premiums could be developed because of cooperatives' financial relationship with their members, as illustrated in Box 36, while providing the insurer with a group of premium payments from an income

source. In addition, cooperatives are more formal entities than ROSCAs, and therefore may make safer partners from a legal perspective. It should also be mentioned that because of the “pseudo-employer” nature of cooperatives, members might have an additional incentive to remain current with their premium payments.

Box 36

Paying premiums in milk at Yeshasvini

Mangsandra is a small village in India with about 1,000 inhabitants. About 200 families are members of the Mangsandra Cooperative Milk Society, which is one of Yeshasvini Trust’s partners. Mr. Krishnamoti, the society’s secretary, is responsible for providing information about Yeshasvini’s health insurance, enrolling members and collecting their premiums. In the first year, 96 persons joined the scheme. In the second year, 230 members and dependants enrolled.

Mr. Krishnamoti reports that it is difficult to pay the premium for a full family at one point in time. However, the milk union developed a solution for this problem. Every morning the members of the cooperative bring in their milk and Mr. Krishnamoti records each member’s contribution in his books. Every day a lorry collects the milk and transports it to the union for processing and distribution. On a monthly basis, the union pays the society for the milk received, and then the society pays the members for the quantity of milk they have delivered in the month.

When members subscribe to Yeshasvini or renew their policy, they can have their premium deducted from the income the cooperative pays them. When Mr. Krishnamoti hands over the list of enrollees to his union, he informs the Extension Officer how many have opted for the premium deduction. The milk union advances the premium payment to Yeshasvini. The advance is then deducted from the union’s monthly payment to the co-op, which in turn deducts it from the share of the respective member. If members decide to enrol their dependants in the scheme, the society only deducts the amount for one person each month and so enables the member to pay in instalments – of milk.

Source: Adapted from Radermacher et al., 2005b.

A less preferable approach to making premiums more “affordable” for clients is to provide separate loans for insurance coverage. For example, some of Microcare’s MFI agents offer loans specifically to pay premiums. By issuing a separate loan for premiums, rather than integrating the premiums into a microenterprise or housing loan, the cost of insurance becomes much more apparent to clients. However, the premium for members becomes more

expensive in absolute terms because of the interest on the loan. An annual premium of US\$50, for example, becomes US\$60 if financed by an annual loan with an effective rate of 20 per cent. This results in an even lower return to policyholders in terms of claims to premiums. Similarly, the lender also takes on the additional risk of loan repayment, and therefore requires full repayment well in advance of expiry of the cover.

TUW SKOK has designed a more appropriate financing mechanism to encourage clients to purchase its more expensive insurance policies. The insurer encourages its partner credit unions to offer interest-free loans to their members, thus making the higher premium amount affordable to low-income members. To compensate the credit unions for the income that they forgo on the loan, TUW SKOK pays them a higher commission. In this way, TUK SKOK has managed to limit its liabilities, while making more expensive products more affordable.

In summary, several lessons emerge about microinsurance financing mechanisms. First, where possible, encourage policyholders to save on a regular basis so they can pay an annual premium. Collaboration with cooperatives allows microinsurers to deduct premiums at an income source. When offering a loan to finance a premium, it is more transparent if the loan is specifically for the premium. However, the increased cost of cover makes interest-bearing loans a sub-optimal choice.

3.2 Balancing efficiency and affordability

The balance between efficiency for the organizations and affordability for clients is a classic trade-off. There are no one-size-fits-all answers and the balance has to be appropriate for the business environment. However, Leftley (2005) provides a useful rule of thumb to address affordability:

Make sure that the premiums are affordable for the poorest clients. The easiest way to define affordable is to work out what cash a client will have spare on an average day. Clients are unlikely to always save for a premium payment, so a monthly premium needs to equate to the cost of a non-essential item (such as a bottle of beer).

When considering the costs to the clients, it is also important to recognize that the premium is not the only expense. If policyholders have to travel to pay their premium, the transportation and opportunity costs of being away from work can be even higher than the premium costs. Consequently, efficiency needs to be monitored and assessed on the basis of transaction costs for the insurer and the policyholder relative to the amount of coverage provided.

To create a balance between efficiency and affordability, some organizations add a fee to the premium for convenience of collection. For example, premiums are reduced for people who pay by standing order or in fewer instalments. This arrangement increases efficiency while making the product more affordable.

3.3 Preventing lapses and non-renewals

Lapses and non-renewals are an important indicator of the appropriateness of premium collection mechanisms. The ideal of completely eliminating non-renewals, however, needs to be balanced with the realities of serving poor people.

Nevertheless, microinsurance schemes should aim to protect themselves from the problems of lapses and non-renewals. Rather than relying solely on penalties, such as terminating cover for late payers, innovations are needed to help people who need leniency. For example, with Tata-AIG's endowment policy, if clients miss premiums, the insurer deducts the missed amount from the accumulated value of the policy to keep the cover in force.

Incentives can also play a role in encouraging payment discipline. For example, policyholders who regularly pay on time could be eligible to pay a lower premium. The key lesson is that rules pertaining to missed premium payments should reflect poor people's realities while being well enough designed not to be abused.

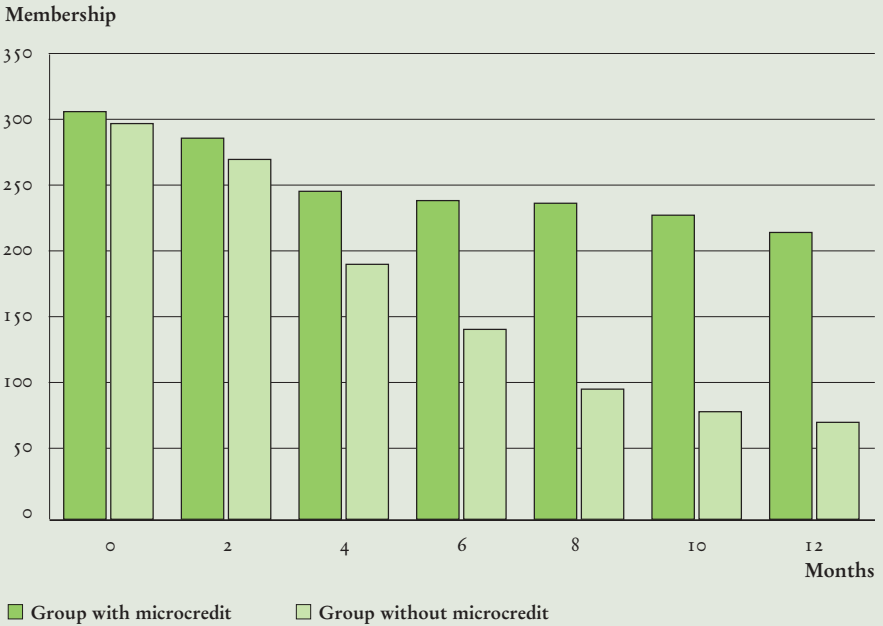
Every time clients have to pay a premium, they are forced to make a purchase decision. This may lead clients to actually choose not to pay for insurance premiums due. Therefore, the more frequent the premium collection, the more chances clients have to relinquish their insurance policies. This is illustrated quite well in the experience of AssEF (Benin), which collects premiums monthly. By December 2003, AssEF had only received premiums from 71 per cent of the people who had enrolled at the beginning of the year and realized that in schemes with frequent premium collection, more promotional and marketing work was needed to encourage clients to keep their policy in force. Following awareness campaigns in 2004, retention rates increased to between 84 and 86 per cent.

Another strategy to reduce lapses is to help policyholders to boost their incomes. Indeed, one of the major reasons why the poor fail to pay their premiums is a lack of money. However, if they had access to a microenterprise loan that enabled them to increase household income, then it would be easier to pay the premium as well. This was certainly the experience of a community-based health insurance provider in Tanzania, which learned this lesson accidentally. UMASIDA began working with two otherwise identical

MHOs – the only difference was that one had access to a separate microfinance institution and the other did not. As Figure 14 shows, the drop-out rate in the group without access to microfinance was much higher than the group with access (Kiwara and Fungu, 2005).

Figure 14

Microinsurance drop-outs and access to microcredit



Source: Kiwara and Fungu, 2005

This finding suggests that the link between microinsurance and microfinance is even more important than just the efficiencies that can be generated through integrated financial services. Access to microfinance may also make it possible for poor policyholders to afford their premium payments more easily. Early on, Delta Life recognized this link between premium affordability and microenterprise loans, and attempted to address this issue on its own. However, as illustrated in Box 37, it is quite risky for insurers to get involved in microenterprise lending directly.

Box 37

Delta Life – combining microcredit and microinsurance

Motivated by the amazing success of microcredit in Bangladesh, Delta also got into the act by offering loans of its own. Besides offering **policy loans** against the surrender value of the policy, as it is required to do by law, Delta also began offering **project loans** for microenterprise activities that were intended to help policyholders increase their incomes and therefore be able to pay their premiums with greater regularity.

Although repayments were in an acceptable range in the mid-1990s, the recovery rate plummeted at about the same time as the insurance portfolio skyrocketed. In fact, one of the explanations for the growth is that organizers (agents) were using the project loans as a marketing tool, promising to provide loans once people bought a policy.

The poor credit quality of the policy loans was not a major cause for concern. They were fully secured and organizers actively encouraged policyholders to pay their premiums rather than their loans, if they had to choose between the two, to keep the insurance contract in force. However, repayment problems with the project loans were a serious concern because the amounts were larger and were only backed by the commitments of other group members. The main problems with the lending activities included:

- Staff were not trained in using a group lending methodology or in managing borrower groups, and therefore the group guarantee was not particularly effective.
- The primary indicators used to measure the performance of organizers were the number of new policies and the amount of premiums collected; their loan repayments were not carefully monitored and chased up.
- The culture associated with collecting timely repayments is quite different from collecting premiums. With a premium payment for an endowment policy, the organization is essentially asking the client to let it hold his or her money, so it is inappropriate to press too aggressively if the client is not able to pay right away. With a loan, however, the client has the organization's money, and the organization has a responsibility to get it back.

Furthermore, as a regulated insurance company, there is some question as to whether Delta is legally able to provide project loans. There are restrictions on the investment practices of insurers and it is probably inappropriate for Delta to be investing premiums in its own loan portfolio.

Source: Adapted from McCord and Churchill, 2005.

4

Premium collection controls

Fraud and mistakes in premium collection are significant concerns for microinsurers as their small margins do not allow for much financial mismanagement. Therefore, effective controls for premium collection need to be in place. There should be a combination of both hierarchical and horizontal controls.

Hierarchical controls require that the insurer set up at least a rudimentary structure within the organization to monitor the quality of the premium collection process. These controls generally work better for insurers that use their own structures to manage the process, than for those that outsource the process to other organizations. Should the latter solution be selected, it might be advisable for the insurer to create horizontal controls, for example, by demanding some sort of collective security from the organization or structure to which the process is outsourced. One solution, which was widely used in Poland until compulsory liability insurance for agents was introduced, was to demand a blank promissory note from the agent, co-signed by one or more agents from the same organization or group. The note could only be used to collect on claims resulting from an agent's fraudulent actions against the insurer, but it created an additional level of security for the insurer through a collective responsibility arrangement between agents.

The significance of fraud should also not be underestimated. Indeed, the structure of entire schemes has had to be modified to deal with it. For example, at AIG Uganda, one reason why the product originally moved from voluntary to obligatory was to reduce the incidence of fraud by the MFI's field officers who took premiums from clients and pocketed the money. By making the product mandatory, the fraud risk was reduced by having premiums paid through cashless transactions in the back office.

ServiPerú has implemented an audit of collected amounts to try to avoid fraud as well as mistakes. The fee collection procedure begins with invoices that are distributed by the collectors in their designated geographic zones. Collectors visit clients mainly at their place of work, up to three times if necessary, to collect the fees. At the end of the day (or more frequently if the volumes are high), collectors deposit the money in ServiPerú's offices or bank accounts together with a record of the payments collected. Once the fee collection period for the month is over, collectors must present a report of uncollected premiums, indicating the reasons for non-collection. Internal auditors follow up with a sample of the non-renewals to ensure that they really did not pay their premium.

5

Conclusion

Premium collection is a daunting aspect of efficient microinsurance provision. Some insurers (or their delivery channels) have found ways to minimize premium collection costs and maximize efficiency. Efficient arrangements mean prompt and full payment without affecting the safety of the premium transfer mechanism or sacrificing customer service advantages. To achieve their financial stability, insurers must make every effort to ensure that premiums are paid on time.

The common premium collection methods respond to client needs to varying degrees. Among the least expensive methods for the insurer is for community groups to collect the premiums from their members and make consolidated payments to the insurer. Collection by insurers of aggregated premiums from MFIs and other groups, which link the premiums to another product or electronically transfer the premiums, can be equally inexpensive. The door-to-door method of collecting premiums from individual policyholders is typically very expensive.

Premium payment lessons include:

- A balance must be maintained between the efficiency of the insurer, and the cash flow and transaction costs of the policyholder. Without an acceptable balance between the two, microinsurance may not succeed. It does not help retention or new client generation if the insurer reduces its collection costs to near zero, while simply transferring the costs to policyholders who may then be expected, for example, to travel to make payments.
- Electronic transfers reduce the costs of all parties involved. Greater availability of savings services for the poor can dramatically improve affordable premium payment mechanisms.
- Where possible, collect premiums from a specific source of funds at a time when those funds are available, such as a loan disbursement, the monthly payment from a milk cooperative, or an employer's salary payment.
- Fraud is an important problem for premium collection. Having individuals handling premiums requires strong controls. Fortunately, some of the more efficient transaction methods, such as electronic transfers, can be among the easiest to control.
- Collection frequency and timing require an understanding of policyholder cash flows and preferences. The assumption that policyholders prefer frequent small premium payments does not necessarily hold true. Market research is required.

- Clients must understand the collection mechanism, and that must lead to an understanding of the policy they are purchasing to move towards developing an insurance culture among the poor. It is not sufficient simply to pay premiums through interest rates where the policyholders do not know they are insured.
- Strategies to minimize non-renewals should take account of poor people's realities. The objective is to keep the policyholder active in paying premiums. It is important that late payment penalties control adverse selection and fraud, but still allow for client retention.

Clearly, efficiency cannot be the only criterion in selecting the best mode of premium collection. The insurer must keep in mind its strategic position and its strong points, as well as the long-term goals it wishes to attain. If the insurer stresses product price as its greatest strength – i.e. attempts to offer lowest possible premium for competitive coverage – it should focus on the least expensive methods, such as electronic transfer from add-on products. If, however, the insurer's strengths lie in a close relationship with the market and high mutual loyalty, the increased cost of door-to-door collection may be offset by lower lapses and lower fraudulent claims from customers who feel they have a closer relationship with the insurer, at the expense of higher premiums. In short, no single aspect can be used to find a solution to a multi-faceted problem of the insurer-insured relationship, the ultimate success of which depends on the long-term survival of the insurer, in turn resulting in secure protection for the insured.

Claims processing

Michael J. McCord and Richard Leftley¹

The authors appreciate the editing and suggestions of the following readers: Aris Alip (CARD), Dobby Mahalanobis (formerly Microcare) and Ralf Radermacher (University of Cologne).

Claims processing, from notification to settlement, is often a costly and time-consuming activity fraught with difficulties. The balance between operational costs – including controls to minimize improper claims – and the cost of fraud, leads to an expensive process, especially for health insurance. Yet for microinsurance to be successful, the costs of operations and controls must remain low to maintain premiums that are affordable to the market.

The claims process for microinsurance differs from that of traditional insurance in its recognition of the realities of low-income life, for example:

- Claims need to be settled rapidly because low-income people have insufficient access to funds to manage the financial costs of risks.
- Health claims should be paid directly to the provider since low-income people frequently do not have the available funds to obtain treatment and wait for reimbursement.
- Conventional documentation requirements must often be replaced by alternative evidence because of the difficulties low-income people have in obtaining some documents.
- The claims process often replaces underwriting because it is cheaper to look closely at a few claims than to require extensive underwriting for large volumes of small policies.
- With small premiums and very limited benefits, the options for different claims documentation requirements must be assessed on the basis of their costs and benefits
- To be efficient, insurers should streamline their controls for the smallest policies, since effort involved in enforcing the controls may be more costly than the actual benefit.
- In general, the process must be as simple as possible.

¹ References in this chapter to Microcare (Uganda), Compartamos (Mexico), Aldagi (Georgia), Kashf Foundation (Pakistan) and Gemini Life (Ghana) are drawn from the authors' experiences, not from the case studies.

This chapter discusses these differences in detail, using examples to illustrate why there is a need to manage microinsurance claims differently from in conventional insurance. It also summarizes the lessons learned in trying to make microinsurance claims processes efficient, effective and controlled. The chapter first looks at the process in general, and then looks specifically at claims notification, settlement, controls and management.

I Introduction

Arguably the most important aspect of insurance for the policyholder is claims. Without efficient and effective claims processing, it will become difficult for the insurer to sell policies as customer dissatisfaction mounts. The right to efficient claims under certain circumstances is what policyholders buy with their premiums.

The cost of processing claims is a critical factor in determining success for insurance companies. They must be efficient with effective controls to ensure that only legitimate claims are settled and for the correct amounts. Yet the controls and processes that work for a wealthier market can be ineffective in the low-income market. Indeed, where claims processing becomes too demanding or too expensive, the related products simply cannot be offered to the low-income market. Such is the critical nature of claims processing.

I.1 The claims settlement process

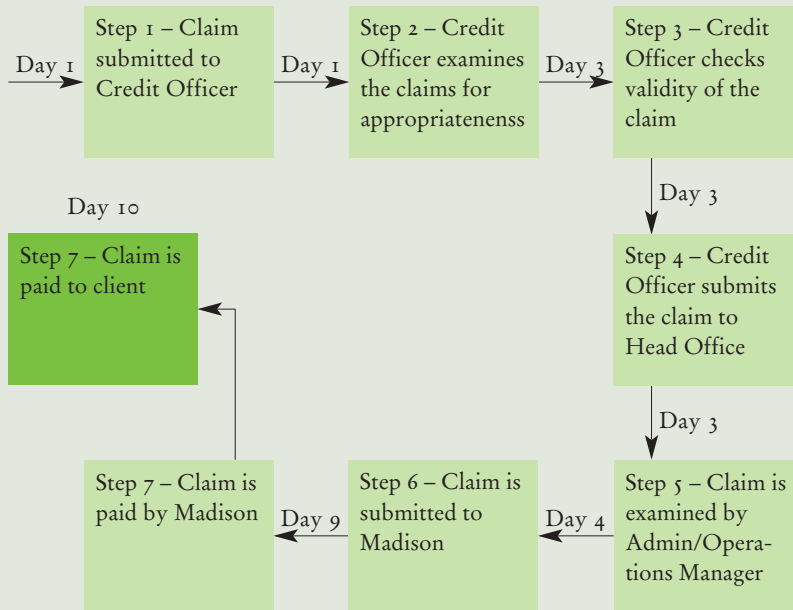
The claims process generally includes the following components:

- An insured event leading to notification of loss
- Collection of required documents
- Presentation of the claims application to an intermediary or the insurer
- Claims adjustment
- Claims settlement

For microinsurance to succeed, it must balance the amount of information required to actually confirm that the event has occurred with the policyholder's ability to obtain that information in a timely and cost-effective manner. Indeed, the claims process must be kept simple to gain the trust of the clients. As illustrated in Figure 15, the process at Madison Insurance in Zambia for example is clear and somewhat timely (compared to other cases).

Figure 15

Typical claims settlement process for Madison's microinsurance product



Note: In a case where documents are not properly filled in (Step 1 or Step 5) the claim will be returned to Credit Officer/client and the process will require additional days – around 2–3 more days.

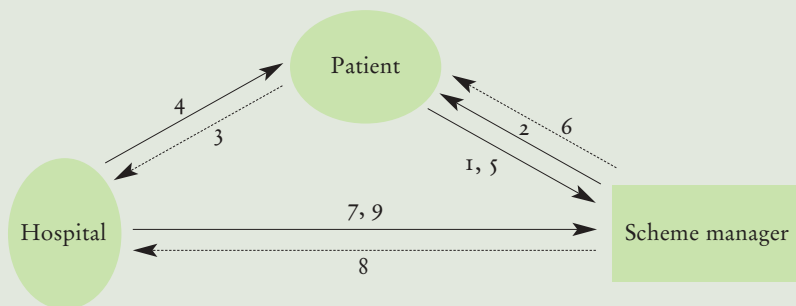
Source: Manje, 2005.

The process at Madison Insurance takes up to 10 days, as long as the documentation is correct and the claim is legitimate. At Delta Life in Bangladesh, the process can take up to 60 days or more. Even though much of Delta's process has been decentralized to the Zone Operations Centres (ZOCs), a number of activities remain at the head office and some claims approvals even require the signature of the Managing Director. Yes, there is a need for strong controls, but every step takes time and costs money, and thus increases operating costs.

Health insurance claims are more complicated than life insurance because a new party is involved – the healthcare provider – and the claim assessment is subjective, requiring medical expertise. Plus, a single policyholder might make several claims during the policy period. At UMSGF, a mutual health insurance programme in Guinea, the process begins with confirmation that the person seeking medical care is actually covered by the policy. The nine major steps in accessing care with UMSGF are indicated in Figure 16.

Figure 16

The claims process at UMSGF



- 1° The patient requests a treatment authorization.
- 2° The scheme manager controls that the patient is eligible for care and issues the authorization.
- 3° The patient goes to the hospital and pays for the consultation.
- 4° The hospital controls the validity of the patient's member card, provides care and issues a treatment voucher.
- 5° The patient hands the treatment voucher over to the scheme manager, once out of the hospital.
- 6° The manager reimburses the patient's transport costs.
- 7° The hospital sends the summary invoice.
- 8° The manager verifies and pays the invoice.
- 9° The hospital issues a receipt.

—> Information flow
> Financial flow

Source: Gautier et al., 2005.

As described in Chapter 2.1, a health microinsurance scheme that requires the policyholder to pay for treatment and then apply for reimbursement, such as the health benefits from VimoSEWA and Shepherd (both in India), does not provide the core advantage of insurance – being able to seek care without having to accumulate funds to pay for it.² In contrast, UMSGF, Yeshasvini (India) and Microcare (Uganda) reimburse the healthcare provider directly.

1.2 Upfront screening versus back-end controls

In many microinsurance schemes, the effort to reduce costs has shifted the normal policy underwriting from the underwriting department to the claims department. Prospective policyholders do not undergo a medical examination, for example. They do not have to present birth or marriage certificates, or health records upon initial policy application. In many cases, screening of

² VimoSEWA is in the process of testing a cashless payment system to overcome this problem.

potential policyholders is eliminated, or to some extent covered by the underwriting of partners. For instance, a woman belonging to an MFI may require microinsurance. She would be accepted automatically for insurance as long as she met the MFI's loan criteria. The cover may even include family members, as with AIG Uganda, Spandana (India) and CARD MBA (Philippines), without any additional underwriting requirements.

Even with individual sales, such as with Delta Life, prospective policyholders simply have to sign a declaration of good health. If anyone suffers an insured event, then the insurer requires confirmation of the declaration, for example, that there were actually no pre-existing conditions. In this manner, microinsurers minimize the workload associated with assessing the mass of applications for cover, and concentrate their efforts on the few claimants.

In general, there must be enough checks and balances to ensure that fraudulent claims are not paid, but the process also must be user-friendly and cost-effective for all parties. However, the whole insurance process must be considered. Where controls are minimized for the mass of insurance purchasers, there is a heavier burden on the claimants. Another strategy for improving efficiency is to have tiered claims requirements, with a limited number of documents and a simple process for the smallest claims, but more stringent controls for larger claims.

The next sections analyse how the key claims sub-processes serve the policyholders, and how microinsurers have made these processes work in an efficient and effective manner.

2 Claims notification

Claims notification occurs on two levels. First, the approach may be either by the policyholder, the beneficiary or the insurer's representative. Then, the application is completed and submitted to formally launch the claims settlement process.

2.1 Approach

Most microinsurers leave the responsibility of initiating claims to the beneficiary. Although several institutions, such as Delta Life, AIG Uganda and La Equidad (Colombia), require beneficiaries to approach the insurer or its agent, insurers can improve their customer service by approaching the beneficiaries, which enhances the credibility of the insurer and strengthens a burgeoning insurance culture.

For MUSCCO in Malawi, beneficiaries generally advise the SACCO that a member has died, although there are instances when beneficiaries are not aware of their designation or the insurance coverage. Under such circumstances, the SACCOs inform the beneficiaries and encourage them to initiate the paperwork. The SACCO has a particular motivation to do so if the member dies with an outstanding loan balance.

Similarly at CARD MBA, the field officer and the group members are motivated to find the beneficiaries to be able to clear the deceased's loan balances. If there is no beneficiary named or that person predeceased the insured, it is the policy of CARD MBA that "in the event of the death of a member without designation of her beneficiary, all benefits due will be paid to her legal heirs according to law" (McCord and Buczkowski, 2004).

Even if there is not a loan to be repaid, with life insurance it is important for microinsurers or their intermediaries to make sure that claims are initiated even if they have to seek out the beneficiary. Trust is still being built with many of these programmes, and claims payments show policyholders that they can trust the insurer to pay.

With healthcare, either the policyholder approaches the insurers for reimbursement, or the insurer keeps the policyholder out of the process by paying the healthcare provider directly. The latter approach is simpler for policyholders and more efficient for the insurers. Grameen Kalyan (Bangladesh) uses a third approach that eliminates the claims process altogether. At GK, members are provided with cards to present at the time of treatment. The treatment cost is then simply discounted and no claim need be made. However, the policyholder still requires cash to access care at the discounted rate, and the cost of medical care that is beyond the capacity of the health centre is covered on a reimbursement basis.

As a means of assistance with the claim process, TUW SKOK (Poland) and Aldagi (Georgia) have implemented 24-hour toll-free help lines to assist in claims queries (among other things). For TUW SKOK, it is interesting to note that only 10 per cent of claims are started through the call centre, while the rest are initiated through their credit union partners – a clear indication of the preference for physical human contact in this process.

2.2

Claims application

Claims applications for insurance products are complicated and can be problematic for low-income policyholders, especially those with limited education. For example, Delta Life's claim form requires significant information including details from local authorities and the deceased's employer, as well as specific information on the cause of death. Completing this form with all

the required signatures and information creates frustration and delays for the beneficiary. Additionally, the claims rejection rate at Delta is about 15 per cent, and this is partly due to incomplete claims applications.

At some microinsurers like Delta, claims documentation has not evolved sufficiently to accommodate the low-income market. For example, while documentation from an employer may not be difficult for a middle-class widow in a city to obtain, it may be a serious challenge for a rural, low-income beneficiary. Claims rejections are often a direct result of the complexity of the forms and the insensitivity to this market's ability to acquire the formal documentation, which can undermine the intention of microinsurance as illustrated in Box 38.

Box 38

Claim rejection: A case of insufficient documentation in Zambia

Philip Zulu's wife died and he began the claims process after her burial. Upon submission of the claim form with burial and death certificates, Philip was advised that he also needed to produce the official Cause of Death Certificate. He went back to the hospital only to be told that it was not possible to produce the certificate because too much time had elapsed since his wife's death. After spending three weeks going back and forth between his MFI's office and the hospital, he eventually gave up on the insurance claim.

Source: Adapted from Manje, 2005.

Some microinsurers, however, have adjusted their claims requirements for their target market, for example:

- VimoSEWA requires a receipt for the wood used in building the funeral pyre
- A burial permit can be used for AIG Uganda and Madison in place of a death certificate

Part of the complexity of claims requirements relates to negative experiences insurers encounter with policyholders taking advantage of the combination of simple initial applications (and thus limited or no underwriting) coupled with relatively simple claims processes. As the controls were weak at both ends of the transaction, CARD MBA encountered a serious and recurring problem with adverse selection, especially for clients' family members. This prompted CARD MBA to initiate a contestability clause for deaths or disabilities that occur during the first year of coverage (*see Chapter 3.1*).

The complexity of the claims form will be partially driven by the extent to which the insurer relies on underwriting through the claims process, as well as the complexity of the product itself. Simple products with few exclusions require less information to make a claim since the insurer does not have

to verify that cause of the claim is covered since (almost) everything is. A simpler claims process not only reduces costs for the beneficiary, the agent, and the insurer; but also leads to a higher level of policyholder satisfaction.

For example, Microcare and Opportunity International use a form for their credit life and funeral policy package that is straightforward (see *Figure 17*), although even this form requires a death certificate, which may be difficult to obtain in rural Uganda. Consequently, Microcare recently started accepting a letter from the clergy or imam who performed the burial if a death certificate or police report is not available. Without such adjustments, beneficiaries can become frustrated, as was the friend of the policyholder in *Box 39*.

Box 39

Beneficiary frustration

One policyholder in Uganda noted: “I know of someone who lost her husband and she didn’t have any money to process the documents, yet her husband had died of an accident and was thus due a significant claim. As a result, she gave up.”

Source: Adapted from McCord et al., 2005a.

The objective is to find a balance between confidence that the insured event has occurred and accepting less than complete documentation. TUW SKOK, for example, requires the death certificate of the policyholder and acceptable means of identification to confirm the identity of the beneficiary. Madison requires the death certificate, a post mortem report, the burial permit, police report, and identification. Often obtaining the required forms is expensive and time-consuming. However, in rural areas, Madison will accept instead three written confirmations of death from the District Secretary, the local chief, the deceased’s employer, or the local police.

Yeshasvini has adopted a very different approach by requiring that claims be pre-approved by its third-party administrator before the insured receives treatment. This approach provides an up-front control to ensure that only authorized services are provided, which has consequently minimized the likelihood of rejecting claims.

In general, claims applications must be simple for beneficiaries to complete, requiring only documentation sufficient to confirm the occurrence of the insured event. Frustrating policyholders or their beneficiaries only hinders the expansion of microinsurance.

Figure 17 Microcare and Opportunity International claim form

Insurance Claim Form – Group Credit Life

Name of lender: _____ Branch name: _____

Name of contact at branch: _____

Contact phone number: _____

Deceased's family name: _____ Other name(s): _____

Cause of death: _____

Date of death: _____ (day) _____ (month) _____ (year)

Total value of claim: UGS _____

Of which UGS _____ is for outstanding loan/interest

Details of the borrower who has died or whose family member has died

Borrower family name: _____ Other name(s): _____

Date of loan disbursement: _____ (day) _____ (month) _____ (year)

We hereby confirm that the details contained in this claim form and attached proof of death are true and accurate to the best of our knowledge:

Signature of claimant: _____ Date: _____

Name of claimant: _____

Signature of loan officer: _____ Date: _____

Name of loan officer: _____

Signature of branch manager: _____ Date: _____

Name of branch manager: _____

Please attach the entire claim supporting documents as required under Condition No. 12 of the Policy namely:

- Death certificate or certified copy thereof;
- Police Report in case of accidental death;
- Copy of the loan agreement;
- In case of a Member's death, original passbook and loan amortization statement;
- Letter from Local Council member;
- Letter from Branch Manager or Group Leader concerned.

2.3 Delays with claims applications

Slow submission of claims to the insurer can be due to a variety of causes. At Madison, late claims are frequently related to documentation problems. It was reported that these stem largely from the loan officers, who are expected to assist with the documentation, yet are too busy chasing delinquent borrowers to spend time ensuring that the claims paperwork is in order. In addition, the MFI's field staff indicated that Madison's claims settlement paperwork was demanding and they wished it were simpler.

In contrast, VimoSEWA's insurance-dedicated *Vimo Aagewans* ensure that members know how to claim and they facilitate the claims process where necessary. VimoSEWA has found that official documents are occasionally not forthcoming, as the local officials request "speed money" to prepare or sign required documents. In these cases, the *Vimo Aagewans* intervene to ensure that the document is procured without additional cost.

The delays in submission to MUSCCO stem from two areas. The first is the difficulty in Malawi in obtaining a death certificate, which MUSCCO requires. The second is more interesting. MUSCCO works through local credit unions which service the insurance policies. To combat the problem of the credit unions severely delaying premium transfer to MUSCCO, claims payments are withheld until the payments are up to date. As a result, the credit unions delayed submission of the claims applications.

AIG Uganda has similar problems with its distribution channels. Although the insurer settles most claims within 30 days of the time it received the claim, the total time between the insured event and the claims payments reaching the beneficiary has been dramatically longer. Claims presented by the beneficiaries to some of the MFIs were being batched – held for weeks – before they were transferred to AIG Uganda's claims department.

For accidental death, where such cover provides an additional benefit, a police report is generally required. Columna in Guatemala further requires a certificate from the forensic doctor, as well as the ambulance report (if an ambulance was involved). The elimination of specific differences between "natural" and "accidental" death would help to eliminate such requirements.

To reimburse healthcare expenses, ServiPerú requires only the policyholder's identification, the medical report, and the invoices, all of which can be collected upon discharge from the provider's care. Having this documentation on discharge makes submission of the documents easier for the policyholder, and because there is the incentive of reimbursement, the policyholders submit their claims quickly.

With TUW SKOK's savings completion insurance, it takes an average of 60 days to receive the claims documentation, in part because the beneficiary is often unaware of the coverage. Additionally, the claims are first presented to TUW SKOK's credit union partners and their incentive to disburse these funds to people who have forgotten about the existence of the benefit has been limited. With its AD&D policy, an average 56-day delay in claim submission is often the result of technical rather than memory problems. TUW SKOK and AIG Uganda have found it takes more time to confirm an accidental death or disability claim because confirmation relies on others, like the police or doctors, who have no incentive to rush with their paperwork.

3 Settlement

3.1 Settlement mechanisms

Several MFIs and credit unions arrange to pay all or part of the claims almost immediately upon being notified of the claim. The Kashf Foundation in Pakistan, for example, originally promised claims payment within one day of the occurrence of the insured event. This worked well for beneficiaries since they could get the funds they needed without having to present the documentation required until later. However, the beneficiaries no longer had an incentive to collect the documents and Kashf was left with receivables and no documentation to use to collect them from the insurer. Subsequently, the MFI changed its policy to payment within five days, but after submission of the documents.

To provide funds to claimants quickly, while still maintaining the incentive to provide the documents, some of Columna's cooperative partners make partial payments when beneficiaries provide the initial documentation. These beneficiaries must meet certain criteria (*see Box 40*) to gain access to the partial payment. Additionally, to protect themselves, the co-ops contact Columna to verify the insured status of the policyholder.

Box 40

Requirements for an advance payment at Columna

The claim will not be rejected if the following conditions are satisfied:

- The policy must be in force.
- The policyholder must have been current in premium payments.
- In case of natural death, a waiting period of 180 days between the effective date of the contract and the death must have elapsed. This period does not apply for accidental death.

- The cause(s) of death stated in the doctor’s post mortem certificate must not include HIV/AIDS.
- In the event of suicide, the policy must have been in force for at least two years.

Source: Adapted from Herrera and Miranda, 2004.

To speed up the settlement process, TYM, CARD MBA and MUSSCO have created decentralized systems that allow branches or agents to pay claims based on receipt of full and proper documentation. Most of the others, including UMSGF, VimoSEWA and Tata-AIG, have a more centralized system that requires presentation of the documentation to the head office claims department for processing. Often this processing includes sample testing of the documentation for validity, and sometimes, as with VimoSEWA, a review of the claim by a claims committee (*see Chapter 4.5*). Medical claims may also be subject to a clinical review as at VimoSEWA and Microcare in Uganda, which is intended to both confirm appropriate care and control over-treatment.

Many microinsurers have their management deliver the claims settlements to the beneficiaries. This activity enhances their public image and promotes the scheme and its benefits to their members. The resulting demonstration effect, whereby others are enticed to join the insurance scheme because they see that claims are actually paid as promised, is a critical element in creating an insurance culture since it enhances trust between the insurer and prospective policyholders.

Disability claimants frequently express dissatisfaction with settlements because of disputes on the extent of the disability. TUV SKOK has developed an appeals process where beneficiaries can, and do, appeal settlements. During the first nine months of 2003, the board considered 69 claim complaints, in respect of which 16 decisions were modified or reversed, 48 were upheld, and five were still in process. Likewise, VimoSEWA has a grievance committee to which people can appeal their settlement.

3.2

Claims rejections

As underwriting requirements are frequently applied to claims submissions rather than initial policy applications, rejections can be an issue for microinsurance. In the case studies, claims rejection rates, where available, were generally between 5 and 22 per cent. The higher rates reported by TUV SKOK’s property insurance, MUSCCO and La Equidad – 22, 15, and 14 per cent respectively – may reflect better record-keeping at the credit union-related

microinsurers. It may also reflect a higher reliance on sorting out underwriting issues through claims. The high rate at TUV SKOK is directly related to water damage claims for which TUV SKOK has implemented a 15-day waiting period to counter a problem with people purchasing policies after their property was damaged by water leaks. This also relates to TUV SKOK's implementation of a US\$27 deductible to minimize frivolous claims.

Claims rejections often occur on several levels, leaving the actual rejection rates rather ambiguous. For Madison Insurance, with a rejection rate of about 5 per cent, it was possible to reject the claims at various levels, including the field officers, their supervisor, head office management or the insurer's claims department. It is only the latter that actually tracks the rejections, but it is likely that most questionable submissions have already been rejected by the time they get to the claims department.

The main reasons for rejecting health claims are related to policy exclusions and the client not understanding, or not being aware of, such exclusions. For example, with VimoSEWA, certain medical procedures and medications are not covered; because members are submitting for reimbursement, there is significant potential for claim rejections. VimoSEWA has worked to combat this through extensive training of its field agents.

Another common reason for rejections among microinsurers has been that policyholders do not realize that they must pay premiums every year to keep their policy in force, so they often believe that they are still covered even though the policy was not renewed. With many schemes, policyholders are not sufficiently informed or they have forgotten the details.

Delta Life has a rejection problem that is common among microinsurers with long-term policies – lapses. For the three years including the period 2000 to 2002, only about 43 per cent of its policies were in force. Thus, on the death of more than half of its policyholders, there would actually be no insurance cover, although the beneficiary would probably receive some of the savings accumulated over the years. It is likely that growth has been restricted by the negative public image of these rejections.

To reduce the rejection rates, two improvements are needed. First, policyholders must be fully knowledgeable about the product they are buying. Besides providing client education, microinsurers should be giving their customers a brochure or simple policy document that states the dates of coverage, the benefits and the claims processes. Second, microinsurers must deal with the root causes of non-renewals and lapses; it is sometimes necessary to develop alternative premium payment options to address the variable and often seasonal nature of household income (*see Chapter 3.3*).

3.3 Time to settlement

On average, settlement times can be anywhere from seven to 60 days, with the longest time to settlement about two years. The average of those case study insurers who were able to provide this information was 24 days.

Claims settlement is often delayed by critical snags in the process. At Delta Life, the snag is simply the policy of the institution itself, since it has not made timely settlements a priority (*see Box 41*). An estimated 10 per cent of death claims take six months or more to be settled because of problems with the mail, manual data systems, insufficient documentation and the centralization of claims processing.

Box 41

The many steps in claims settlement at Delta Life

It is interesting to note the number of staff involved in checking and approving a claim, which has a direct impact on claim settlement efficiency as well as cost. At Delta Life, besides the three people in the unit office who review the claim, there are one or two people from the ZOC's servicing department, and then at least three at head office, along with the MD if the claim is above US\$180. This does not even include the role played by the control and compliance department which ensures that all required signatures are on the form. It is no wonder then that claims settlement takes at least a month, and often much longer. In the future, Delta hopes to decentralize the entire claims process to the ZOCs, but such a change does not appear imminent.

Source: Adapted from McCord and Churchill, 2005.

When working with MFIs, the delay may be due to the MFI agent not concentrating on the delivery of microinsurance products. In one case study, the time to settlement was tracked for several specific policies (*see Table 25*) and it was apparent that the MFI was creating substantial delays. The insurer should intervene to address this problem. However, because these are related to a group policy through the MFI, the insurer believes it has satisfied the policy requirements once it pays the MFI. Though this may be technically correct, it is important to recognize that when receiving queries from beneficiaries, the MFI's staff blame the delays on the insurer. Indeed, even with the rejected Case 6, the MFI's staff continue to report to the beneficiary that they are waiting for the insurer to pay the claim.

Table 25

A sample of claims durations

	<i>Days from death to claim reaching the insurer</i>	<i>Days from claim arrival at insurer to payment to the MFI</i>	<i>Days from MFI receipt to beneficiary receipt</i>	<i>Total days from death to beneficiary receipt</i>
Case 1	91	38	280	409
Case 2	60	26	101	187
Case 3	46	21	101	168
Case 4	75	33	221	329
Case 5	77	31	Loan only	108
Case 6	86	30	Rejected	N/A
Average	72.5	29.8	175.8	278

Source: McCord et al., 2005a.

Several of the case study institutions aim to achieve “rapid” claims payments. The partnership document of Madison Insurance gives the commitment that it “shall expeditiously settle claims within a maximum of seven working days”. Shepherd’s insurer has committed itself to settling claims within 15 days. For ServiPerú, the government has taken the lead by mandating that all claims be paid within 30 days. AIG Uganda has agreed to pay claims within 14 days, though its average is much longer. An interesting alternative approach to assurances on claims was implemented by Gemini Life Insurance Company in Ghana; if it takes longer than 14 days to settle a complete claim, a penalty of 25 per cent of the claim amount will be payable to the beneficiary. Microcare provides a similar offer.

Delays with LIC’s claim settlements were unacceptable to the clients of VimoSEWA, as they were often taking one month or more after all documentation was submitted. VimoSEWA management decided to explore alternatives. Aviva Insurance was selected to replace LIC in 2005 because it permitted VimoSEWA to pay the life claims, reducing reimbursement time to one week. For health and asset insurance, VimoSEWA has worked with the private, non-life insurer ICICI Lombard since 2003. This relationship improved claims settlement through the provision of a reimbursement fund, out of which VimoSEWA pays the claims and is then reimbursed by the insurer.

It is when they submit a claim that policyholders find out if their premium has been well spent. All clients expect claims to be paid quickly. However, “quickly” means very different things to different people. For example, in Zimbabwe (see Box 42) or South Africa, where people have become used to informal burial societies, paying claims quickly may mean within one day; whereas in Zambia, where burial societies are less prevalent, quickly means

within a week or two. These different perceptions have a huge effect on the claims process, the cost of delivery and the level of client satisfaction.

Box 42

Efficiencies of informal insurance

Zambuko Trust, a Zimbabwean MFI, conducted market research to explore possible insurance opportunities. The research revealed that over half of Zambuko's clients had contributed to an informal burial society. These burial societies are organized by a person in the community who collects small regular contributions from members. The contributions are saved in a bank (or sometimes in a tin) and in the event of the death of a member or someone in their family, the burial society pays a sum from the saved contributions.

Due to the limited number of people in each burial society and the limited geographical scope, the claims are often paid within hours of the death. Since these burial societies are common in Zimbabwe, most low-income people are familiar with funeral insurance and expect claims to be paid within 24 hours.

Source: Adapted from Lefitley, 2005.

Efficient controls are critical to any insurance product. As the experience at Delta illustrated, having more people review a claim does not necessarily lead to better control. There are significant advantages in having claims payment decisions close to the beneficiary. The success of the India examples shows that even with a regulated insurer as the backbone of the scheme, durations can be reduced by creating structures within the delivery channel to facilitate these transactions. However, the data in Table 1 shows that MFIs are not always the best arbiters of client needs, and thus insurers must ensure that the final client is being satisfied.

4

Controls

Insurers are not successful just because they can get claims paid quickly. They must ensure that the claims are legitimate and correspond with the policy requirements. For example, for an accidental death claim, they do not just need a document from the police confirming death, but they must also ensure that:

- the document is legal
- the death was an accident
- the person who died is actually covered by the policy
- the death occurred within the policy period, and
- the policyholder was up to date with premium payments when the death occurred.

Insurers make promises to cover risk events under certain circumstances. Their policyholders, and indeed even their intermediary agents, are motivated to try to cheat this system, especially if the policyholders are not the owners of the scheme. If insurers are to stay in business, they must maintain strong yet efficient controls.

4.1 Claims adjustment

Some microinsurers, like TUV SKOK, work with professional claims adjusters. TUV SKOK does this with property claims where valuations may be rather complicated. Those offering health or disability insurance often use physicians to review and adjust claims. For life insurance, most microinsurers utilize a combination of paperwork and the relationships of the intermediary agents. TYM for example, uses the local Woman's Union to help with claims adjustment; MUSCCO uses its SACCO partners.

MUSCCO has found claims adjustment a challenge because Malawi lacks a national identification system. Consequently, it is unable to confirm that the claimant is actually a policyholder. Several institutions overcome this, or reinforce the confirmation of identity, by requiring agents who know the deceased to actually view the body. CARD MBA uses its volunteer coordinators, selected from among their membership, to visually confirm the loss. Others, like VimoSEWA, require a photo of the deceased. Opportunity International Bank Malawi overcame the lack of national identity cards by introducing smartcards that record clients' fingerprints.

Confirming the cause of death as HIV/AIDS has proven elusive, especially in high-prevalence countries, as illustrated in Box 43.

Box 43

Claims adjustment and HIV/AIDS

In the face of high potential loss rates from HIV/AIDS, several microinsurers implemented specific exclusions for deaths caused by HIV/AIDS. Both AIG Uganda and MUSCCO have come to realize that excluding HIV/AIDS is an impractical solution. Both institutions provide insurance mostly or entirely to borrowers who must fulfil the credit criteria of the lender. The loans are almost always short-term. Thus, due to the fact that the borrower has been able to qualify for the loan and its short duration, much of the likelihood of a claim due to HIV/AIDS has been removed. Also, in Uganda and Malawi, HIV/AIDS is rarely listed as the official cause of any death. Deaths of HIV/AIDS sufferers typically result from pneumonia or TB or some

other opportunistic disease. These factors basically render the unpopular HIV/AIDS exclusion ineffective. Thus, the exclusion has been removed from AIG Uganda and MUSCCO policies.

Adapted from Enarsson and Wirén, 2005; and McCord et al., 2005a.

In 2004, VimoSEWA improved its approach to claims adjustment when it trained three office staff in claims investigation techniques. The cell was trained by the COO for the purpose of discreetly procuring correct ground-level information from hospitals, doctors, nursing staff, and relatives and neighbours of the claimants. They were also trained to analyse healthcare bills and information on claimants' income, work and family, depending on the details of the claim. Investigation results are discussed only with the claims coordinator and COO along with the CEO for final decisions.

4.2 Other general controls

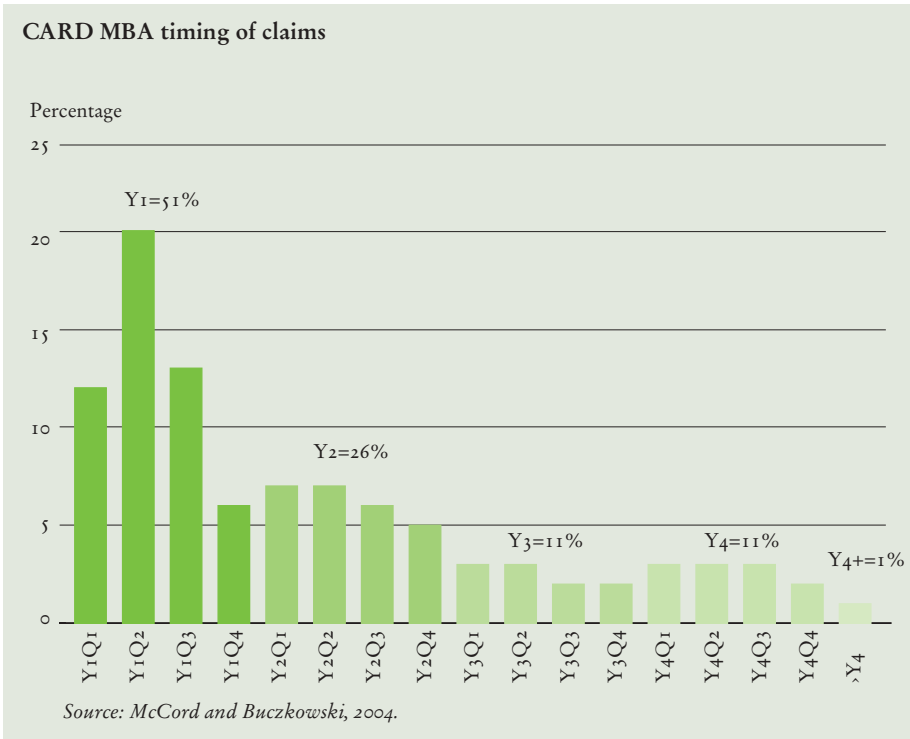
Some controls relate to the structure of deductibles and co-payments, which limit the volume and value of claims. Additionally, these play an important role in limiting the incentive for fraud by the policyholder. For example, with property claims, TUW SKOK limits settlements to 50 per cent of replacement value. In this way, the policyholder still takes a 50 per cent stake in the risk of loss.

Sometimes common controls cannot be implemented; for example, Tata-AIG could not introduce a waiting period because the national insurance regulations prohibit it. The regulators feel that such a provision can cause ill will among policyholders with little knowledge of insurance when a claim arises within the waiting period. Tata-AIG has paid claims within the first month of policy activation.

At Grameen Kalyan and BRAC in Bangladesh, staff members frequently interact with clients and get to know their families personally, which works as a moral deterrent against fraud and false claims. Many MFIs have observed that borrower groups tend to exclude those individuals that have a history of poor health or are known to be sick. Group members fear that such individuals will struggle to repay their loans, leaving other members to repay them under the mutual guarantee. Opportunity International has used this observation in negotiating with insurance companies in Africa and the Philippines to remove waiting periods and existing illness restrictions from their life insurance products.

In addition to other methods, CARD MBA uses data to control claims. The microinsurer has examined at what point in time during policyholders' relationships with CARD claims are being submitted. As shown in Figure 18, over half of all claims arise within the first year of membership, which suggests an adverse selection problem. However, this finding must be analysed in context; due to the rapid growth, 40 per cent of all CARD members were in their first year and 40 per cent of its members were responsible for 51 per cent of claims.

Figure 18



As mentioned in Chapter 2.1, the risk of fraudulent claims in life insurance is relatively low because it is hard to fake a death, especially in a rural community where people tend to know one another. However in health insurance the risk is much greater. Common fraud problems that occur with health microinsurance include:

- physicians submitting invoices for care never provided, possibly splitting the settlement with the policyholder,
- policyholders obtaining cover for persons not covered by the policy,
- over-treatment by providers,
- submission of fraudulent invoices by policyholders.

Countering these fraud problems calls for close claims analysis, but even more importantly, requires that controls be built into the systems to stop fraud before it occurs. For example, to control fraud, Microcare places a receptionist in the waiting room of the approved healthcare provider. These qualified nurse receptionists ensure that only covered individuals receive treatment by checking the identification cards; the photos on the card are matched to both the patient and the database available to the nurses.

Using this technology, Microcare can ensure at each stage that only covered care is provided, and the insurer has an immediate record of the treatment costs that can be compared to the hospital's invoice when it arrives. Thus, Microcare can make sure that its policyholders receive the care they buy, and is able to keep the premiums lower. However, although this extensive system mitigates policyholder fraud, it does little to encourage true managed healthcare because Microcare has no control over the physicians and clinics.

As a means of controlling the financial transaction, Delta Life pays about half of its claims with crossed cheques (requiring the payee to deposit the cheque into a bank account). This is a common procedure at insurance companies. However, frequently the beneficiary does not have a bank account into which to deposit the cheque, and many banks are not prepared to open an account since they know that the payee will deposit and immediately withdraw the proceeds, and then close the account. Even when banks agree to open an account, they impose heavy service charges that make the insurance transaction more expensive for the beneficiary.

The bottom line with microinsurance is that controls must be strong, yet must reflect both practicality and the market situation. It makes little sense to implement expensive controls that the market cannot comply with, or that cost more to implement than the likely cost of the aggregate loss. As margins are smaller with microinsurance, the cost-benefit analysis is particularly critical.

5 Claims considerations in product design

A simplified product design will greatly aid the claims process. Microinsurance product designers must think through the steps policyholders will go through to make a claim. When CARD MBA tested a health insurance product, it found the risk management and paperwork simply too costly and onerous for the MBA and its members, so it pulled the plug on the product. Claims processes and costs must be addressed and honestly recognized in the product development process.

In general, life policies are relatively easy because there is one obvious insured event – the death of the covered person. Several programmes offer simple policies where if the person dies (and is covered, and the death is proven), the beneficiary is paid. Other programmes add complexity with exclusions for suicide, death due to civil strife or acts of nature. The author's favourite microinsurance exclusion is one for policyholders who die "while a passenger in a rocket-propelled vehicle". The greater the number of exclusions, the more complex the settlement process will be.

A range of benefit options also adds complexity. Some microinsurers offer an additional benefit (double indemnity, for example) for accidental death; Columna has special accidental death benefit for certain causes of death, for example while travelling as a passenger in public transport or in a lift, or as a result of fire in a public building, where the insured sum is multiplied by three. With accidental death policies, two problems occur. First, there is significant ambiguity surrounding the definition of an accident, which can lead to conflicts in the adjustment process – something that public relations-sensitive microinsurers should want to avoid. It is difficult and unpleasant to explain to expectant beneficiaries that something they see as an accident, or a special accident, is not one.

A second issue with accidental death claims is that people have an incentive to convert a death due to illness into an accidental death. Microinsurers have reported cases of beneficiaries creating fraudulent police reports and bribing physicians for fraudulent post mortem reports. The incentive generated by a potentially significant claims settlement has led many people to indulge in fraudulent activities. The problem is eliminated when there is a simple death policy where any death leads to a common settlement. Comparamos, for example, uses the slogan "death is death"; with its insurer partner Seguros Banamex, it treats all deaths in the same way. Policies with simply-defined benefits and simple claims procedures are critical for efficient microinsurance operations.

Tata-AIG has developed a broad strategy in designing its microinsurance products. Its objective is to limit costly underwriting, and to focus instead on claims verification. While reducing its operating costs, the problem with such a strategy has been that its products have been mis-sold by commission-seeking agents who have sold products to people who do not qualify for them. When such people make a claim, it may subsequently be rejected during claims verification. This does not create a good impression of Tata-AIG, nor does it help create an insurance culture.

In some mutual and community-based programmes, like ServiPerú, the scheme managers found that it was important for members to self-limit their claims behaviour and worked to raise awareness among policyholders of the

benefits of prevention and minimizing claims so that prices could be kept low in the future. This reduces the volume and value of claims, ultimately allowing for a potential reduction in premiums. BRAC takes an interesting approach to this type of limitation for their health insurance, allowing each cardholder only one referral reimbursement per year.

6 Conclusions

In summary, the following key lessons and recommendations about claims management are worth considering:

- To be efficient, insurers should streamline their controls for the smallest policies, since the effort needed to enforce the controls may be more costly than the actual benefit.
- Efficient microinsurance must have simply-defined coverage, appropriately rapid claims settlement and controls that can be easily applied.
- The closer the settlement is to the policyholder, the faster it can be provided, though there are potential issues of control and inconsistent application of claims rules that need to be monitored.
- Claims must be based on documentation that is appropriate for the clients.
- The overall microinsurance processes are more efficient and cost-effective when the underwriting is conducted through claims rather than at the point of purchase. However, where the controls are minimized for the masses of insurance purchasers, there is a heavier burden on the claimants and a risk of mis-selling.
- With health insurance, the greatest benefit for policyholders is when the insurer settles directly with the provider. Procedures and controls can be more efficient when the providers are responsible for initiating the claims.
- A settlement appeals committee is important to offer beneficiaries an opportunity to have their claim results reviewed and clarified.
- Distribution agents such as microfinance institutions are not always the best arbiters of client needs, and thus insurers must make sure that the final client is being satisfied.
- Computerization greatly enhances the potential of developing and implementing efficiencies, and may be the most important input to efficient processes, especially for health insurers.
- A simple brochure for each client showing the breakdown of fees and benefits, the coverage period, and describing the claim settlement process, would be a worthwhile consideration.

John Wipf and Denis Garand

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Commercial insurance companies employ actuaries, specialists trained in the mathematics of insurance and risk management, to calculate the financial impact of contingencies for which policyholders are insured. More specifically, the actuary ensures that the company's premium rates are prudent and sufficient, that its reserves for future liabilities are adequate, and that the policy dividends paid to its policyholders are equitable.

Similarly, a microinsurance programme should also contract the services of an actuary to derive the premium rates for its products and to assist with other aspects of managing the scheme. In the beginning, many unregulated microinsurers underestimate the technical rigour required to price products correctly. They often yield to the temptation of duplicating products and rates from the commercial insurance market or from other microinsurance programmes without considering the underlying assumptions behind those rates.

The main objective of this chapter is to illustrate how insurance products are priced and how to design and maintain databases so that they can be used for pricing purposes and sound management, and to highlight some good and bad examples of microinsurance pricing derived from the case studies. This chapter is particularly relevant for unregulated microinsurance schemes that carry their own risk, but also for organizations that distribute products underwritten by insurance companies – if distribution channels understand pricing, they will be more adept in managing data and negotiating with insurers.

The discussion is limited to life and health insurance, although many of the issues and points made apply to pricing other products as well. It is by no means an exhaustive treatment of the subject – indeed, an entire book could be written on microinsurance pricing.

For the information to be useful, parts of the discussion are by necessity somewhat technical – this should also convey the message that professionals are needed to price products correctly. The example illustrated in Box 44 is a

common occurrence. Informal insurance schemes that do not rely on actuaries to price their products, including several of those depicted in the case studies, tend to be too cautious and charge too much, or they under-price the product and threaten the viability of their scheme – neither of these results contributes to successful microinsurance.

Box 44

Pricing problems

An MFI in India started its microinsurance programme with a single-level premium for life insurance coverage for all of its clients. In February 2003, GTZ sponsored a training session on pricing. When the rate components discussed in this chapter were reviewed, the MFI realized that its scheme would be bankrupt within a few years. The session helped managers understand their data needs, how data are used in pricing, and that all of the components of pricing must be considered when deriving the appropriate rates needed for long-term MI sustainability.

Aside from the direct underwriting impact of pricing, it is important to note that appropriate pricing can help build trust in the microinsurance product, while a poorly-priced product can lead to abrupt adjustments in premium rates and an erosion of confidence in the scheme.

I Database design requirements for pricing (and sound microinsurance management)

Premium rates are established by the actuary using available **experience data**. In the early days of a microinsurance scheme, when there is still no specific data available on the proposed participants for calculating their expected claims, population statistics and data from similar programmes have to be used to the extent that they are available. The actuary must then rely on observations of and assumptions about the participants and their proposed or ongoing insurance scheme to adjust that information in the calculation of the premium rates.

Actuaries prefer to use the specific data of the group or population to be insured since this will result in more reliable and accurate rates. Credibility of the data increases with volume. In deriving crude group mortality rates for example, the actuary would consider a minimum of 10,000 life years of exposure¹ to be necessary for the data to be considered fairly credible – less credibility would be attributed for smaller data amounts.

¹ One life-year exposure is equivalent to a person being exposed to the risk of dying for exactly one year. The crude mortality rate is the number of observed deaths divided by the number of exposures.

From the beginning then, it should be clear that one of the key determinants of a scheme's long-term success is a properly designed and well-maintained database and management information system (MIS) for capturing and screening the data used in subsequent pricing reviews. The main objectives of an MIS are to accumulate data and to assist with managing the insurance scheme in a professional, efficient and technically prudent manner. The database design should be based on the relational database model, built with the help of IT professionals, and with inputs from an actuary and the management of the scheme (*see Box 45*).

Box 45

Database design problems

TYM in Vietnam operated its microinsurance scheme for several years. However, the database was not properly designed and maintained, which made it very difficult later on to analyse and re-price products. For example, the relational database table with loan information could not be properly linked to the table containing member information, making it impossible to calculate risk exposures by age and gender.

Grameen Kalyan's micro health insurance has kept detailed information at each of the health centres. This information could have been very useful for analysis and pricing purposes if each client's membership number had been retained from year to year rather than assigning a new number on each renewal, or if the records had had another unique identification field for each member. This unique identifier would have allowed the actuary to track the exposure and claims for each member through the years.

Source: Tran and Yun, 2004; Ahmed et al., 2005.

Great care and time must be invested in the design phase of the database since it is the foundation of a good MIS. The following tables of information must be included:

a) Institutional and branch information

If the scheme is servicing several institutions then the details of each institution needs to be maintained.

b) Participants' information

Who is covered? What are the attributes of the participants? As a minimum, the following attributes must be included:

- | | |
|--|--|
| - Unique identifier or key | - Name |
| - Gender | - Date of enrolment in the scheme |
| - Date of birth | - Primary occupation / livelihood |
| - Marital status | - Residence: urban or rural, city, province |
| - Number of children
(calculated field if beneficiary
and covered dependants
history is kept) | - For health coverage, a recent photo
should be on file for printing ID Cards |

These data are used to prepare a demographic profile of the group, which is needed for projecting future mortality trends. If the country has a national ID number then that could be used as the unique identifier; otherwise, the scheme will have to generate its own unique ID number that clients should retain throughout their history with the scheme.

c) Beneficiaries and covered dependants

For health insurance, some of the same data should be maintained for each covered dependant, including name, unique identifier, gender, date of birth, relationship to the participant and a photograph.

d) Coverage history

What are the coverage details? A coverage history for each enrolled person has to be kept, not just the coverage currently in effect. If a change is made to an individual's coverage then a new record should be created in the coverage history table with the effective date of the change as one of the fields in the record.

Apart from monitoring and for administration purposes, the main objective of keeping a coverage history is to permit the reconstruction of a complete history of each person's exposure to every covered risk so that expected claims can be calculated for comparison with actual claims experience (this will be further discussed in the next section). In fact, software applications can be developed to monitor the expected claims in relation to actual claims on an ongoing basis – this is a powerful tool to assist microinsurance managers. For example, at Yeshasvini in India, management noticed that one of its accredited hospitals was performing an unusually large number of hysterectomies. On further investigation, it found that the medical management of patients was not appropriate, resulting in termination of the relationship with the hospital. AssEF had a similar experience, as described in Box 46.

Box 46

Importance of a health insurance MIS: Experience of AssEF

For its health insurance scheme, AssEF in Benin carefully monitors actual claims in relation to expected claims. In some cases, substantial differences between projected and actual figures emerge. Once it identifies the discrepancies, then management can determine how to address them. From the results in 2004 (*see table below*), two issues captured management's attention: the high rate of prenatal consultations and nursing services.

	<i>Expected frequency (%)</i>	<i>Actual frequency 2004 (%)</i>	<i>Estimated cost</i>	<i>Average cost 2004</i>
General practitioner's consultations	107	102.4	392	231
Gynaecological consultations	10	3.3	1 400	1 525
Prenatal consultations	12	33.1	259	368
Postnatal consultations	4	0	370	-
Minor outpatient surgery	8	1.2	1 694	1 960
Outpatient nursing services	100	175.9	1 050	1 011
Deliveries (excluding caesareans)	4	3.7	3 360	8 655
Caesareans	0.5	0.6	35 000	35 000
Hospitalization	10	20.1	2 327	1 373
Surgical procedures (excluding caesareans)	2	0	34 320	-
Laboratory tests	20	58	2 730	2 938
Radiographies	5	4.2	4 865	3 589
Ultrasounds	5	8.1	4 284	4 069
Generic and essential drugs	144	157.1	2 954	2 281

At AssEF, a three-month waiting period for new members is the principal barrier against adverse selection. This safeguard appears to be sufficient to reduce opportunistic behaviour with regard to outpatient consultations and hospitalizations; however, it remains to be proven in terms of planned health services. For example, by monitoring claims, management identified a strong adverse selection phenomenon with respect to prenatal consultations (subsequently affecting deliveries in 2005).

This phenomenon was heightened following the numerous drop-outs that began in mid-2004, since many of the remaining women were pregnant. Specific measures could have been implemented to curb adverse selection, such as increasing the waiting period for prenatal consultations and deliveries. However, a decision was made to use the phenomenon for marketing purposes. As the claims in question were not out of control, they could be used to increase the visibility of the scheme, particularly with a target group made up of women. The frequency of utilization is very carefully monitored

and measures could still be implemented if the risk of adverse selection becomes too significant.

As for the nursing services, the frequency of utilization was also monitored according to the healthcare provider, and these results showed that one clinic had a much higher claims experience. In this case, microinsurance clearly led to a behaviour change. As the beneficiaries were insured, the clinic asked them to come back several times during the same illness to receive treatment; the first visit is recorded as a consultation and the subsequent ones as nursing services. The scheme's management approached the clinic and discussed the anomaly in treatment patterns, and this resulted in a return to more normal claims experience. Had the management not monitored the situation, the claims would have exceeded the financial resources of the plan and possibly resulted in its bankruptcy. A well-designed database and MIS is crucial for microinsurance management.

Source: Adapted from Guérin, 2006.

e) Premium history

For each product, a premium payment history must be kept for each insured, including the following fields: payment date, payment amount and receipt number if applicable.² Besides being needed for administration purposes, the premiums history will be used to study the pattern of drop-outs (lapses and surrenders), which in turn will affect the pricing of many products (*see Box 47*). For products with savings and equity accumulation features, the payout values will depend on the premium history since interest must be credited accordingly.

Box 47

VimoSEWA's renewal rates

VimoSEWA in India implemented a new MIS system in 2001, which permitted it to measure its renewal rates. Management was quite surprised to learn that the organization had a very low renewal rate – just 22 per cent for members paying annual premiums. Having been made aware of the problem, management took steps to increase the renewal rate by communicating the value of maintaining insurance to members and by setting target renewal rates for each *Aagewan* (sales promoter).

² Some group plans enrol all members of the organization, such as a dairy cooperative, and in some of these cases only collective group records can be maintained in practice.

A proper database is required to measure renewal rates. The renewal rate for Year X is the number of members that renew in Year X+1 divided by the number of members from the same cohort that were insured in Year X.

Source: Adapted from Garand, 2005.

f) Claims history

Who claimed? When did they die, or become sick or hospitalized? What amount did they claim? What was the incurred cost, covered or not? What was the method of treatment? What was the cause of death or hospitalization? When was the claim received? What was eventually paid, and on what date? For health claims, the cause of the claim should be recorded in International Claims Diagnostic (ICD) format and charges should be broken down by benefit category.³ The claims experience is crucial for ongoing management and monitoring purposes and is also a primary source of information for pricing (*see Box 48*).

Box 48

VimoSEWA's claims processing

VimoSEWA's MIS recorded the date of the claim incidence, the date the organization received the claim and the date the benefit was paid to the member. This data showed that there were long delays in processing claims. Further analysis showed that part of the problem was due to members not knowing how to submit claims. Armed with this knowledge, VimoSEWA increased its efforts to educate members and to reduce time for claims reimbursement. Over three years, time for claims payment was greatly reduced – from three months to two weeks. Members acknowledged the improved service.

Source: Adapted from Garand, 2005.

g) Product rules/policy history

The coverage rules for each product must be defined and kept. Although the coverage history described above could also be used to capture product rules, it is much more efficient to separate general types of coverage information that does not vary too much between individuals and maintain it in a separate set of tables. This is needed to complete the expected claims information mentioned above.

³ The ICD table was developed by WHO and assigns a code to various disease categories. The most recent ICD table is available on the WHO web site.

All records should be kept indefinitely, either in the current database or in an archive, for cumulative experience and actuarial analysis. The data should be carefully managed just like any other resource of the microinsurance scheme.

Actuaries attach great importance to the way data is collected and managed because erroneous and incomplete data can be more of a liability than an asset if misinterpreted. To ensure the completeness and integrity of the data, robust controls and thorough cross-checking should be built into the MIS. Standard coding values and formats should be used to simplify queries and to improve consistency. For example, participants' occupations should be selected from a menu of standard occupation codes rather than being typed in each time.

All data should also be verified as far as possible against other independent systems such as accounting. For example, premiums, commissions and claims must be balanced against the accounting system at the end of each accounting period to make sure that there is consistency between the two systems (which is also a very useful integrity check for the accounting system). Furthermore, database changes should be monitored and confirmed regularly against manual systems.

2 Pricing components, key factors and methodology

The primary objective of any pricing exercise is to ensure that premium rates are sufficient to realize the scheme's aims and meet its obligations in the long run, while maintaining equity among the participants. For life and health insurance, rates can either vary by age (age-structured) or, as is most common, remain the same for all participants (sometimes described as "community rating"). If level rates are used, it is advisable to impose a maximum entry age and perhaps also a maximum coverage age (otherwise the rates will probably be too high, which in turn will affect the marketing of the product). An alternative to a maximum coverage age is a declining schedule of benefits for the older participants.

Several components should be considered in establishing premium rates. Each component must be carefully calculated from the experience data and/or from other available information. As mentioned above, to the extent that specific data is unavailable, the actuary must make reasonable assumptions based on experience, industry studies and observations from similar programmes.

It is very important to note that in microinsurance product design, communication methods, management practices, and many other factors will impact the observed experience. In populations where insurance awareness is low, it may take much more time for claims rates to stabilize and to reach

predictable levels. For example, even though it was serving a similar insured population, Yeshasvini's claims experience increased from Rs. 65 (US\$1.43) per insured in Year 1 to Rs. 86 (US\$1.89) in its second year of operation. The most likely reason for the higher claims cost in Year 2 is that there was a greater awareness of the insured benefits and claims procedures.

2.1 Life and savings products

The main components for pricing life and savings products are the following:

a) Rate of mortality

Typically the actuary chooses an appropriate mortality table prepared by collaborating companies within the insurance industry and adapts this to the microinsurance group. In the absence of industry tables, population tables prepared by World Health Organization (WHO) or others may also be used and adapted to the particular group of microinsurance participants, although this is not the optimum approach.

The selection and adaptation of the mortality table is a critical step in the pricing process for life insurance. Ideally, the final table should be tested against the database of participants by calculating the expected claims and the number of deaths over a selected retrospective study period, and then comparing these results with actual experience in the same period. This comparison should be conducted over each risk subgroup if possible, such as those defined by a combination of age, gender and geographic location. This test will determine the appropriateness of the mortality model and is only possible if the scheme has accumulated reliable data, as described in the previous section. The actual-to-expected claims test can be performed iteratively until the selection of mortality table and required adjustments are completed. The final result is the mortality pricing model for the group.

Whenever possible, the actuary should use a demographic profile of the prospective insured group when calculating the expected aggregate mortality rate instead of simplifying the calculation by using an expected average age. The latter approach is not very reliable (*see Chapter 3.6*).

The participation level is a very important consideration in preparing the mortality model. **Mandatory participation of all eligible members of the target group is recommended.** If participation is optional, then adverse selection will significantly increase the expected mortality rate.

Another important factor is the **expected trend in mortality**. In that regard, the actuary must take into account the influx of new participants in the next few months or years. For example, if the projected growth rate of the scheme is "high" and if new participants are a targeted segment of the

population such as younger women entrepreneurs, then the aggregate mortality rate will probably decrease or remain stable over time. Conversely, low growth rates are likely to result in an increased aggregate mortality rate as the group ages. For age-structured rates, this is less of a concern. However, for level premium rates, the future trends in expected mortality must be incorporated carefully.

For example, with VimoSEWA's voluntary scheme, the rate of mortality changed dramatically in a few short years as a much larger proportion of younger women entered the programme, and due to wider participation compared to the earlier years (*see Table 26*).

Table 26

Evolution of life mortality rate at VimoSEWA

<i>Year</i>	<i>Number insured</i>	<i>Rate per thousand</i>
1998	25 000	19.3
1999	31 000	14.2
2000	30 000	12.1
2001	29 000	11.6
2002	93 000	4.3
2003	110 000	3.7
2004	104 000	4.7
2005	117 000	3.2

Source: Garand, 2005.

HIV/AIDS is a major factor introducing long-term changes and trends into mortality rates. In regions with significant epidemics, the mortality rates can double or even triple, particularly in the income and age bands typically served by microfinance institutions and community-development NGOs.

Upon completion of the mortality model, the actuary will calculate the **expected claims** component of the premium rate, taking into account the product features and benefits payable contingent on death.

Other products like disability or health insurance will also require pricing tables, though based on contingency rather than mortality rates. Most of the above considerations will still apply.

b) Drop-out rate

The drop-out rate (lapses and surrenders) is another very significant factor in price determination. A lapse means that premium payment is late beyond the grace period (which is normally 30 to 60 days), whereas a surrender is notice of termination or non-renewal beyond the allowable reinstatement period.

It is important for the actuary to be able to prepare a schedule of drop-out rates by age, gender and time since enrolment, and correspondingly, to understand what proportion of the lapses will reinstate their coverage within the allowable reinstatement period. This information can be derived from the premium history database described above.

Depending on the product, the drop-out rates and the pattern can either improve or decrease the profitability of the microinsurance programme. For all products, a high rate of drop-out will increase expenses. However, if the product has an equity or savings component of which a portion is forfeited through early surrender, then a high surrender rate can actually improve profitability. The actuary may choose to use some of the projected forfeited equity to fund other benefits and thus reduce the overall premium rates.

c) Risk loading

Actuaries use risk mathematics to compute an appropriate risk premium, which is meant as a **provision for adverse deviations** (PAD) from expected claims over the short to medium term. Expected claims computed from experience and mortality tables will probably never be realized exactly⁴ and the risk loading is a provision to increase the probability that the actual claims will not exceed net premiums over a predefined time period.⁵

In general, experience with larger groups of homogeneous participants (in terms of age, gender, health, occupation, etc.) and with identical coverage is less likely to deviate significantly from the expected claims (i.e. smaller variance) than that of smaller groups, groups with diverse participants, or groups with several coverage options.

d) Uncertainty loading

The actuary may include an amount to compensate for uncertainty. In general, the more assumptions that have to be made, and the less reliable and sparser the data, the greater is the uncertainty.

e) Profit or contribution to microinsurance surplus and equity

To expand the scheme, some profits are needed. The desired profit may be expressed either as a loading or as a separate component of the net rate.

⁴ Technically, the expected claims computed from the data can be regarded as an estimate of the mean of the true underlying aggregate claims distribution.

⁵ The risk loading is computed based on a desired probability of having sufficient net premium to cover all claims over a defined period, typically 1 to 5 years. A loading that ensures adequate net premium with a probability of 95 per cent is higher than a loading that ensures same with probability of just 90 per cent, for example.

f) Expenses

The expected expenses incurred for marketing, underwriting, claims payment, premium collection and administration must be loaded into the final net rate. To do this correctly, a thorough analysis should be made to determine how the expenses of the entire scheme are incurred, and then the expenses should be projected and allocated to the various products on an incurred basis. Arbitrary expense allocation will result in cross-subsidization of products (although this may be desired in some cases).

Recently Grameen Kalyan's health insurance programme was analysed to compare premium by health centre to the cost of operating the centre. The analysis showed that some centres were producing a surplus after taking account of only their local costs, but before factoring in the head office cost allocation and the depreciation of their equipment. Future pricing reviews of its products must include the costs of running the entire programme.

g) Expected investment earnings

Expected investment earnings are used in combination with expected mortality rates to prepare the net rates for life insurance before expense loading.⁶ For example, Yeshasvini invested the initial annual premium and earned interest of Rs. 2 (US\$0.04) per insured person, which helped cover some of the administrative expenses. The actuary, therefore, needs to consider how excess premiums will be invested before they are used to fund the scheme's expenses and incurred claims. Moreover, the timing and frequency of the premium payments (*see below*) affect the investment earnings as do the quality, liquidity and rates of return of the selected investments.

As discussed in Chapter 3.6, the main risk in pricing long-term insurance products is the accuracy of assumed investment earnings. Long-term fixed rate guarantees are especially dangerous if the asset used to invest premiums (such as 20 to 30-year bonds) is not identified and purchased at the time the guarantee is given. Interest rates can drop relatively quickly, so it may be impossible to invest in assets that provide the returns needed to fund the rate guarantees. A shortfall of just a few basis points may well lead to eventual bankruptcy due to the effect of compound interest. One solution is to link rate guarantees to investment instruments such as government-issued bonds or five-year average term deposits in commercial banks.

⁶ More precisely, expected investment earnings in combination with expected mortality rates are used to calculate the actuarial present value of expected claims, which is then used to derive the rates.

h) Product design

Product design features affect all the pricing components. For example, one common product is level-term life insurance. If the coverage is linked to loans from an MFI, the risks covered are predominantly women's lives (where women are the target clientele of the MFI). By also providing coverage for the clients' spouses and children, the risk pool is significantly altered, especially since most male spouses are often older than their wives and because males usually have higher mortality rates. Product features such as **waiting periods** and **pre-existing illness exclusions** are also important pricing considerations (see *Chapter 3.1*).

i) Timing and frequency of premium payments

These have to be factored into the premium rates. For example, if the annual premium payable at the beginning of the coverage year is P, the equivalent monthly premium is higher than $P/12$ for three reasons: 1) the additional collection expenses (twelve transactions rather than just one), 2) lost interest earnings and 3) the fact that those dying will not complete the monthly premium payments.

j) The size of the microinsurance group

This affects the expense levels due to economies of scale, and it will greatly influence the required risk loading discussed above.

k) Participation rates

These affect the mortality rates, morbidity rates and the expenses. A community with 100 per cent participation will have lower per-capita claims expenses than a community with only 10 per cent participation. In the latter case, adverse selection comes into play because the families who believe that they will receive a benefit are more likely to enrol in the insurance programme.

l) Growth of the microinsurance scheme

This, together with inflow of new participants, is a critical factor in mortality trends. The addition of older or younger insured populations can dramatically change the expected aggregate mortality of the group.

m) Stability of the group

A group with low renewal rates is likely to experience higher mortality and morbidity as an element of adverse selection takes hold.

n) The livelihoods, occupations and activities of the participants

These greatly affect the health, mortality and morbidity rates and thus the expected claims.

o) Inflation rates

These will affect expenses and perhaps benefits depending on the product design. Inflation rates will usually have an effect on investment earnings as well.

p) Reinsurance

This can be used to manage some pricing risks. Theoretically, and all things being equal, reinsurance can result in lower net rates due to the reduced risk-loading requirements, but this depends on the design of the reinsurance programme and on the reinsurer. However, in many cases the reinsurance programme adds an additional cost.

2.2

Pricing health insurance

Most of the discussion in the previous section also applies to pricing health insurance. However, there are some additional considerations and issues which make pricing health insurance especially challenging.

Expected claims costs are computed using a combination of morbidity rates, claims incidence for each benefit category, and claims amount distribution by benefits category – claims must be separated in the database because this will enable separate pricing of each benefit category. Claims costs should ideally be segregated by age, gender, and geographic location. For this purpose, there is nothing which compares to an extensive and consistent database to estimate claims distributions.

Incidence rates are dependent on the insureds' utilization rates and utilization trends – and these can change significantly in a very short time. Utilization is dependent on prevailing characteristics of the insured, including their overall health, access to services, understanding of how to use services, the dignity with which services are provided and many other factors. For example, VimoSEWA introduced a child benefit in its hospitalization plan in 2002. In analysing the experience, it was observed that there was an increase in the number of families participating in the child health coverage and the increased participation decreased average utilization rates (*see Table 27*).

Table 27

Claims experience of VimoSEWA's child benefit

Year	Actual claims cost per insured
2002	Rs. 97
2003	Rs. 85
2004	Rs. 70

Source: Garand, 2005.

Inflation rates of benefits are a key consideration for health insurance – they are very difficult to predict and are usually much higher than the Consumer Price Index (CPI). To decrease the uncertainty in pricing, the product should be designed with maxima for each benefits category as well as an overall annual maximum.⁷ Alternatively, one could follow the approach used by UMSGF and Yeshasvini, and negotiate fixed tariffs for services, such as surgery, with healthcare providers.

Co-payments have an enormous effect on the rates because they result in decreased incidence and shorter hospitalization confinements. The claims database can be utilized to determine the effects of deductibles and co-payments on the premium rates. In many cases, the poor are hesitant to use health services as they lose several days income and incur increased travel expenditure, effectively creating a “hidden” co-payment or deductible.

The **geographic location** of the insured normally has a significant effect on access to service, thus affecting the pricing.

3 Modelling techniques

Actuarial modelling is an excellent approach to business planning and pricing, since it captures the numerous and complex interactions of many different parameters. Models are not a substitute for credible data, but enable the actuary to leverage the available data. Comprehensive models can reveal issues that are otherwise difficult to imagine, allow the user to test “what if” scenarios, and can be used for ongoing monitoring and detection of developing trends. In addition, a model allows for pricing multiple products at the same time.

For example, the pricing actuary may ask, “What would be the compounded effect on the premium rates and on long-term microinsurance solvency 5 to 10 years from now if the waiting period for Product A were reduced from one year to six months, and if the maximum entry age for the microinsurance programme were lowered from 64 to 60 but the exit age

⁷ An overall annual maximum will also limit the number of claims of higher risk individuals or families within a defined period.

raised from 65 to 69, and if a death benefit of US\$50 for the member's children aged 90 days to 21 years were added?", and so on. Such complex questions may arise during the business planning stages of a microinsurance programme or may be raised by the management at any time – a good model can be used to test these types of scenarios.

The model should use the current database for evaluating key parameters. For example, demographic profiles, incidence rates and lapse rates should be updated before running the model. The expenses of the organization based on past experience and on the microinsurance business plans should be loaded into the model.

The output of a quality model includes prospective income statements, balance sheets, and cash flow statements. These outputs are indicative in nature and one must be careful to limit their interpretation. Generally, the user adjusts the premium rates and product features until the projected statements look reasonable.

4

Conclusions

The key messages in the chapter are as follows:

- Pricing microinsurance products is very technical and requires assistance from an actuary.
- The actuary has to consider the whole package – target market, product design, marketing and communication, administration and claims service – to set an appropriate premium. These parameters must be monitored periodically to anticipate changes in pricing.
- Accurate pricing begins with a quality database. The database should be designed by an IT professional with inputs from an actuary to ensure that the data are relevant for pricing purposes.
- Data, like any other resource, must be carefully managed.
- Health insurance is more difficult to price than life insurance. Rates should be reviewed every six to 12 months because utilization and inflation trends can change rapidly.
- Microinsurance modelling techniques can be used to price products more accurately, produce business plans and detect developing trends.

3.6 Risk and financial management

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Sound financial management is one of the most important requirements for long-term success in the insurance business. It is an especially complex task because the bulk of an insurer's assets are used to back future benefits that are payable contingent on the occurrence of insured events.

Many microinsurers – particularly those with roots in the development community – fall short of having an adequate level of financial and risk-management skills. Many of these, however, offer only short-term, lower-risk products, although a few carry higher-risk, long-term products (*see Chapter 2.2*).

The aim of this chapter is to provide a brief overview of the major financial management issues that the insurer must master, as well as to offer practical and important financial management suggestions specific to microinsurance. In particular, this chapter discusses: 1) the risk of insurance, 2) capital requirements, 3) reserves, 4) reinsurance, 5) investment management and 6) profit distribution.

I The risks inherent in insurance products

Insurance is the business of risk management and therefore requires a thorough understanding of the nature and degree of the various risks present in the products being offered. Most of these risks are also inherent in microinsurance products. For microinsurance to be sustainable, four major categories of risk have to be managed and understood. The quantification of these risks is the basis for determining the actuarial reserves and the amounts of capital required for the long-term sustainability of a microinsurance programme (*see Box 49*). The four major categories of risk are: 1) pricing inadequacy, 2) asset depreciation and default, 3) interest rates and investment mismatch and 4) general contingencies and management.

¹ The references to Kasagana Ka (Philippines) come from the authors' experiences.

Box 49

Actuarial reserves and capital defined

In this chapter, actuarial reserves are assumed to reflect the actuarial present value of expected liabilities² less actuarial present value of expected premiums inclusive of the appropriate margins as determined by a pricing actuary. These reserves are assumed to be reflected as a liability on the balance sheet. Furthermore, to simplify the discussion, the term “capital” here includes retained earnings, surplus, claims fluctuation and contingency reserves, guarantee funds deposited with regulators, etc. **It includes all assets over and above those funding the actuarial reserves.** Capital is assumed to be accessible in the event of deficiency in actuarial reserves.

1.1 Pricing risk

Pricing is such an important topic that Chapter 3.5 is devoted to it. As pointed out in that chapter, pricing requires an accurate projection of the claims expected to be incurred, preferably based on specific experience data.

Many microinsurance programmes have inadequate and inappropriate data and therefore have difficulty obtaining an accurate projection of claims, which could lead to an erroneous pricing of their products. In other words, a lack of experience data exposes these programmes to a pricing risk. As discussed in Chapter 3.5, a good MIS together with a well-managed database enables the pricing actuary to derive the expected claims cost and other pricing components. The chapter also describes the specific data elements that must be included in the database.

It is important to understand that actual mortality and morbidity costs vary by age, gender, region, socio-economic status and other parameters. In the absence of good data and in places where the demographic profile of the target market is not well understood, microinsurers that charge level rates to all participants in life and health insurance schemes are exposed to a significant pricing risk since this practice requires an inherent assumption regarding the risk profiles of the target market. Removing exposure to erroneous risk profile assumptions would necessitate premiums being fixed according to age, sex and other parameters.

For simplicity and popular marketing appeal, or due to legal requirements such as in South Africa, most microinsurance programmes price on a community basis, which means that all risks within a specific scheme are charged the same premium. Consequently, the microinsurance scheme is exposed to a

² Put simply, it is the value of the expected amounts payable at various times in the future due to contingencies such as death or due to policy maturity, discounted to the present date by the application of particular interest rates.

much greater pricing risk since both the current profile and the future trends in the target population's demographics become major factors in the expected claims. Even more importantly, the **participation rate** becomes a crucial determinant of success because it, in turn, affects the demographic profile of the participants (a subset of the target population) and the aggregate risk exposure.

In general, a low participation rate will result in much greater risk exposure since older and higher-risk individuals tend to enrol first and participate more readily. Conversely, a higher participation rate generally means that a larger proportion of lower-risk individuals are also participating. This is clearly demonstrated by VimoSEWA's experience, where the mortality rate declined from 19 per thousand in 1998 to five per thousand in 2004 (see *Table 26 in Chapter 3.5*). This positive trend is largely the result of the organization expanding from 30,000 to more than 100,000 lives covered, and this wider participation involving an increase in younger members.

One of the most common pricing risks for microinsurers is deriving a community rate for group products based on an average age of a group, rather than basing it on the actual age-sex demographic profile of the group. The mortality rate for the average age of a group, for example, is a poor substitute for the weighted average mortality rate since the latter measure takes into consideration the demographic profile of the group.

For instance, the average age of the 8,500 members of Kasagana Ka (KSK), an MFI operating in Manila, is 39.95 with 98.67 per cent women. The mortality rate for KSK using an average age of 40 is 2.292 per thousand per annum, while using the more appropriate weighted average mortality rate based on the MFI's age-sex profile results in 3.395 per thousand. Since the expected mortality rate using the average age is just 67.5 per cent of the weighted average mortality rate, if the average age were used as a basis for deriving the level rate for a compulsory life product, for example, the product would be significantly under-priced.

Although mortality rates usually vary by region,³ the geographic parameter is much more important for many risks covered by non-life insurers. In health insurance, for example, not only do morbidity rates vary by region, but more significantly, access to treatment, manner of treatment, and costs of treatment can vary greatly between hospitals.⁴ Regional claims costs vary for other products as well, such as those offering protection against natural disasters.

³ This fact is generally accepted by most actuaries and due to numerous factors such as diet, living conditions, lifestyle, cultural practices, livelihoods, access to medical treatment, etc.

⁴ In some countries such as in India, expected claims costs are higher in urban areas than in many rural areas partly due to increased incidence resulting from better access.

Even if all the correct information were available for projecting claims, actual claims patterns usually change from the expected pattern assumed by the pricing actuary. Since higher than expected claims could severely impair the insurance programme, a certain amount of capital is required in case the underlying risk is underestimated. While this pricing risk is generally present in all insurance programmes, it is much greater for microinsurance since the risks are not as well understood by the actuaries.

Another significant pricing risk for longer-term life and savings products is the assumed interest rates. Projected claims, other benefits and expenses are discounted to their present value using assumed prospective interest rates – the lower the assumed interest rates, the higher the present value of future costs reflected in the premium rates, and vice versa. The pricing actuary may sometimes assume an overly optimistic interest rate to lower the present value of claims and the resulting net premium rate. This error, however, could jeopardize the programme later on when the assumed interest rates are not achieved. On the other hand, the actuary could be overly conservative and assume too low an interest rate, thus making the price uncompetitive. Either way, the interest rate assumption results in a significant pricing risk for longer-term products. This and other pricing risks need to be backed up by extra capital.

1.2 Asset depreciation and default risk

Investment income from the assets of an insurance company is an important source of overall income. An error in managing investments can therefore be a major cause for the failure of insurance companies. One common error is excessive exposure to assets that do not generate the expected interest and dividend payments. This is known as “asset default risk”.

In capital markets, asset quality is generally rated inversely to its promised returns; this reflects the situation that, all other things being equal, assets promising a high rate of return also carry a greater risk of default. High interest is often associated with a higher risk rating of the investment instrument. So, prudent investors may prefer safer investments. However, an over-investment in perfectly safe investments could lead to erosion of real portfolio value over time, since returns are not much higher than (or may even be lower than) inflation rates. On the other hand, overexposure to high-risk investments could lead to a severe decline in portfolio value due to asset default. The challenge of good investment management is to achieve a balance between these two extremes through a diversified investment policy. The objective is to optimize investment returns while maintaining an adequate level of security and the required degree of liquidity so that assets can be available when required.

Most microinsurance schemes do not accumulate significant assets because they provide only short-term products, such as credit life or health insurance. However, for those offering long-term products, such as endowments and pensions, it is necessary to build up substantial assets since benefits are paid out in the distant future. Surplus accumulation of a successful programme over the years may be another significant source of assets.

Whatever the source, assets must be invested and monitored diligently. Adequate controls have to be in place to ensure that funds are not diverted for personal use by managers and the board of directors. Financial institutions usually introduce the following measures in their investment policy:

- permitted investments
- permissible asset classes for diversification
- maximum investment permitted with any one financial entity or in a particular asset
- discretion permitted to persons responsible for investments
- procedure for modifying policy
- reporting requirements

Even with a good investment policy in place, however, the choice of investments is very limited in many developing countries, which may also lead to problems.

There is sparse information in the case studies on how assets are managed. Few microinsurers have built up substantial assets, although the exceptions include VimoSEWA (India), CARD MBA (Philippines), Delta Life and Grameen Kaylan (both Bangladesh). The first two have invested the majority of their assets in related organizations, which could lead to problems due to the covariant risk.

One microinsurer in India was granted funds to invest in order to generate interest revenue to cover operating expenses. These funds were all invested in the stock market. The picture seems rosy at the moment because the markets have risen substantially of late. This investment policy is however extremely risky due to lack of diversification by asset class and could come back to haunt the organization. Stock markets can be extremely volatile and some good luck is required to exit just before a major decline.

As the other extreme, an example of overly cautious investment policy is employed by ALMAO in Sri Lanka. Its investment strategy requires that 30 per cent of all assets be invested in treasury bills and the balance in fixed deposits. The yields of this portfolio are below the current inflation rate in Sri Lanka. Over time, this will erode the real value of the investments.

In summary, diversifying assets appropriately over different investment vehicles and durations is one of the most practical and important practices in managing the asset default risk.

1.3 Interest rates and investment mismatch risk

Investment mismatch risk can be illustrated by an example. If an insurer offers a savings product that guarantees that deposits will double in five years, this guarantee can be fulfilled only if the insurer consistently earns a 14.8 per cent return on investment. Any insurance product that has an implied interest rate guarantee would require the insurer to match asset flow with liability flow at the correct investment earnings rate. Failure to do so exposes the institution to future losses if interest rates change. This is called investment mismatch risk.

Using the above example, an investment yielding higher than 14.8 per cent over five years is needed to meet obligations, to cover expenses, and to generate a surplus. Just how much higher depends on the efficiency and objectives of the insurer. The section below on investment management discusses this in more detail.

1.4 General contingencies and management risk

Insurance operations always have to be actively and professionally managed. Poor management can lead to eventual dissolution or bankruptcy. A lack of skills and understanding of how to operate the programme is a substantial risk for a microinsurer. This risk is compounded further if the board of directors is inadequately skilled in overseeing management (*see Chapter 3.8*).

Inadequate management and governance is perhaps the biggest risk for many microinsurance programmes (*see Box 50*). As described in Chapter 3.10, benchmarking can help to overcome some of this risk, though it can never be completely eliminated. For this reason, greater efforts should be made to increase the expertise of directors and managers.

Keeping the above risks in mind, the microinsurer has to manage its financial resources in such a way as to meet its obligations in a timely fashion. An essential function is to maintain appropriate accounting records and prepare financial statements, including balance sheets and cash flow statements.

Box 50

Management risk illustrations

Over the years, the International Cooperative and Mutual Insurance Federation (ICMIF) has had several members that have experienced difficulties and even failed. A review of their experiences often exposes management and governance problems, such as:

Company 1 started as an agency to serve the insurance needs of various affinity organizations⁵ and businesses – agricultural, marketing and financial – in a developing country with a centralized economy and a state insurer. When the market was liberalized, the agency was converted into an insurer owned and controlled by the affinity organizations. The company lasted barely five years.

Company 2 was set up as the first mutual society after a 50-year break in a country in transition where the insurance industry, until the Second World War, had followed the mutuality tradition. A principal sponsor is a farmers' organization. A persistent challenge has been competition from stock companies selling products at lower prices, particularly to farmers. The company is still struggling to survive – with a perpetual shortage of capital.

Established in the mid-seventies, **Company 3** provided protection to middle- and low-income earners. Group life insurance showed early promise, but the company got into individual life insurance which is a significantly different product. The company mistakenly thought it needed a vast network of branches spread across the country in order to distribute the product. It died a long, slow death in the 1990s.

Company 4 is owned by a large number of savings and credit cooperatives and their national federation. Together they have controlled – and run – this insurer for a dozen years. Managers have come and gone through a revolving door rotated by the board of directors, whose ambitious forays into unfamiliar lines of business have not failed to oblige – with stunning losses.

Source: Adapted from ICMIF, 2005.

⁵ The term affinity organization or group refers to an association organized according to cooperative or democratic principles, such as farmers' associations, savings and credit unions, housing cooperatives, trade unions and the like.

2 Capital requirements

Microinsurance programmes should aim to accumulate capital to deal with the risks discussed above. Since microinsurers generally start out with insufficient capital, the pricing actuary should initially increase the risk and uncertainty loadings described in Chapter 3.5. These loadings can be used to build up surplus and contingency reserves over time. Interest rate margins should be used to reduce the assumed and expected rates of return in pricing longer-term products – the margins can be used to at least partially fund asset default and mismatch risks. The premium rates should also include a small loading for catastrophe reinsurance, as discussed below.

Mathematical ruin theory can be used by actuaries to describe the capital needed for long-term solvency. In practice, modelling techniques are superior and can be easily customized for testing the long-term capital requirements of specific microinsurance programmes.

There is also the possibility of having too much capital. Although one could always create scenarios that consume all the accumulated capital, the question of scenario plausibility then arises. Commercial insurers in Canada are required to test their capital adequacy annually under all scenarios that the insurer is exposed to where there is at least 1 per cent probability of the scenario being realized.⁶ Life insurers are required to test their capital adequacy using five-year scenarios and non-life insurers use two-year scenarios.

MUSCCO and CARD MBA have accumulated significant capital due to very good current operating results. For MUSCCO, there is a possibility of higher future claims due to HIV/AIDS and the organization no longer has reinsurance, so capital accumulation is certainly justified. CARD MBA, on the other hand, has possibly accumulated too much capital over the years. Microinsurers such as CARD MBA may have to consider reducing premium rates (or increase benefits) and determine a strategy to pay out excess capital equitably to clients and members.

3 Reserves

The most general technical definition of a reserve is the actuarial present value of future liabilities less the actuarial present value of future premiums. In practice, there are many different kinds of reserves on the books of insurers, generated by the features of their various insurance products and by the nature of their operations.

⁶ Assigning probability to a scenario involves professional judgment on the part of the Chief Actuary of the insurer.

Like other insurers, most microinsurance programmes maintain reserves to ensure that they can pay their obligations when claims are submitted. To get a true picture of the financial condition of a programme, the reserves must be calculated using actuarially acceptable methods. They must then be reflected in the financial statements; the reserve levels are reflected as a liability in the balance sheet, while increases and decreases in reserve levels should be treated as an expense in the income statement.

Insurers often use proxy and simplified methods to estimate the true actuarial reserves, although regulators may prescribe the methodology and the limits of the assumptions that may be used. For example, the regulator may specify a mortality table and interest rate assumption to be used in the valuation of whole life products in the insurer's annual report.

One of the most common microinsurance products is credit life. In the case of credit life, the future premium payable is usually zero because a single premium is collected by the microinsurer at the time the loan is issued. If the premium is collected up front, the accepted practice for reserve calculation is as follows:

Actuarial Reserves =

Gross Unearned Premium Reserve (GUPR) + Incurred but not Reported Claims (IBNR) + Claims in Course of Settlement (CICS) + Provision for Adverse Deviation (PAD)

A good practice for microinsurers is to calculate GUPR on a loan-to-loan basis at each reporting period. This applies to the other reserve components as well. PAD is usually determined at the discretion of the actuary. The method of calculating these values is beyond the scope of this chapter.

As mentioned above, to get a true picture of the financial condition, reserves must be calculated accurately and this is best achieved by a good actuarial system accessing a clean and current database. Software tools for calculating reserves should be programmed by an actuary. If a product has guarantees beyond one year, the reserves should be calculated directly by the actuary.

Calculating the reserves is only the first step. The microinsurer must make sure that the reserves are fully funded at all times and that the investments backing the reserves are properly managed.

4

Reinsurance

Reinsurance is a risk-management tool that should be used by the microinsurer if possible. It is generally used to stabilize the financial condition of the insurer. Chapter 5.4 deals with this subject in greater detail, but a brief discussion is warranted here since reinsurance is an important aspect of financial management.

In commercial markets, reinsurance is used to meet regulatory capital requirements or even as a source of capital for companies with limited means. Sometimes, insurers buy reinsurance in order to receive professional advice from reinsurers.

Reinsurance is not a magic wand you can wave to turn a losing proposition into a viable entity. The a priori condition for reinsurance to add value to the business results is that the insurer has a viable product or one that can be made viable if appropriate measures are taken. This requires the maintenance of appropriate records of the insured, claims management, financial reporting and an appropriately articulated business plan.

There are several types of risks faced by an insurer which can be managed through reinsurance. **Catastrophe risk** is a rare and asymptomatic risk such as an earthquake or tsunami, which particularly affects asset security and life insurance portfolios. Similarly, a major epidemic such as the widely expected avian flu could affect health insurers. A portfolio that is too geographically concentrated is much more susceptible to the financial impact of a catastrophe.

There is no single and universal definition of the dimension of damages that constitute a “catastrophe”; the term has a different meaning for climate extremes than for health impacts or wild fires. In some cases the catastrophe is measured in relation to the size of the portfolio, while in others it may be expressed relative to household annual income. Generally, a single catastrophic event could impair the financial condition of the insurer due to the unusual number of claims.

Catastrophe coverage is available to most commercial insurers – the premium is usually very small in relation to the cover due to the very small probability of occurrence. Reinsurers can take on this risk because they spread the risk across the globe by, in turn, reinsuring with other reinsurers. The international nature of reinsurance enables risks to be spread across national boundaries.

Claims severity risk refers to a disproportionate risk within a pool of homogenous smaller risks. A credit life programme covering 20,000 loans of US\$500 and one loan for US\$10,000 is a very clear, simple example. In this case, the insurer should only retain a small portion of the single large risk, say

US\$500 of the US\$10,000, and cede the remaining US\$9,500 to a reinsurer because a claim from that particular borrower would severely impact or even wipe out the entire surplus of the programme. Such a reinsurance cover is termed surplus or individual excess-of-loss reinsurance.

Aggregate claims are affected by **claims incidence risk**, which is a fluctuation around the mean of the claims distribution, i.e. the expected number of claims. In practical terms, the actual value of claims is greater than the expected value factored into the rates. A microinsurer can manage this type of risk through quota share and/or aggregate stop-loss reinsurance.

For pension or disability plans, **duration of claim** or the probability of someone collecting a pension or disability benefit longer than expected is a risk that impairs the financial results. Individual excess-of-loss cover could be used to manage this risk if it is available.

Reinsurance is also used to even out **irregular claims patterns**. Over a certain period of time, such as a year, an insurance company may be able to pay all its claims. However, these claims may not be spread evenly during the year and may instead come in irregular patterns such as a flurry of claims or a large claim in a particular month. Reinsurance allows the reinsured to smooth out its claims obligations and to reduce the uncertainties of irregular claims. Reinsurance also enables insurers to limit year-to-year fluctuations. Essentially, the reinsured borrows from the reinsurer in bad years and pays back when its loss experience is good.

For some microinsurers there is little need for surplus or quota share reinsurance. A specific example of this is when a microinsurer covers a “large” number of “homogeneous risk” clients with a simple term life product that has identical “low” coverage for all. In this case, the number of claims is likely to remain stable from one period to the next since the number of clients is large – in other words, the variance for claims incidence is small due to the Law of Large Numbers. The actual number of claims should be close to the expected number of claims if the pricing has been done properly. Since the insured amounts are assumed to be identical for all participants there is no claims severity risk (i.e. zero variance in benefit payout when a claim does happen).

Other microinsurers, however, do need surplus or quota share reinsurance because they cover a relatively “small” number of lives (hence they have a larger variance in incidence than for a larger risk pool) or because they have little or no capital. Reinsurance would also be necessary if a few individuals represent a significant portion of the total sum insured. Some actuaries use the rule of thumb that individual risk retention should not exceed 0.5 per cent of the microinsurer’s capital and surplus. So, for example, for a microinsurer with US\$100,000 capital and US\$20,000 surplus, the

maximum retention should be 0.5 per cent of US\$120,000 or US\$600 – the remaining risk should be reinsured. This formula is too simplistic because it does not take into account the number of risks covered, but it provides an initial indication.

It is very prudent for microinsurers to take out catastrophe reinsurance if it is affordable and available. However, one of the major hurdles is reinsurers' reluctance to provide reinsurance to microinsurance schemes because they do not understand the microinsurance market. In addition, many microinsurers are not legally registered and the reinsurer is restricted to doing business only with licensed insurers.

The case study on AIG Uganda illustrates the limited relevance of reinsurance for some microinsurance products. For this commercial carrier, the decision not to reinsure is logical as the sums insured are small and spread over 1.6 million people living in a large geographical area. Perhaps catastrophe cover would be a suitable risk-management strategy for this pool.

MUSCCO in Malawi, however, could not buy reinsurance even if it wanted to because it is not a registered insurer. Furthermore, although it does not appear vulnerable to an imminent and sudden risk of increased mortality rates, it has built up a large fund to cover future claims increases that could also cover claims fluctuations. As with AIG, however, catastrophe reinsurance would be advisable if it were available.

5 Investment management

As mentioned above, the objective of a good investment programme is to optimize the value of the investment earnings while maintaining appropriate liquidity and asset security to meet obligations as they arise. This is achieved by diversifying by asset type, with a cap on any one investment. Many organizations define their vision of a sound investment policy by outlining the objectives, responsibilities of managers, monitoring reports, categories and permitted asset types.

A tendency and common mistake made by developing insurers is to overinvest in property, often for reasons of prestige or in the (speculative) hope that its value will rise and produce a large capital gain. As a general rule, property should not exceed 10 per cent of invested assets, especially since it is very illiquid.

A critically important function for any insurer exposed to longer-term liabilities, such as endowments and pensions, is matching anticipated positive cash flow generated by assets (such as anticipated maturities, interest earnings and dividends) to expected negative cash flow arising from liabilities (largely expected benefits to be paid). This is known as **asset-liability**

matching.⁷ The objective is to ensure that the pattern and magnitude of positive cash flow closely matches that of the negative cash flow. This must be constantly monitored and in practice requires a projection of the liability stream consisting of expected claims and expenses (for example), which is then compared to the expected inflow stream made up of scheduled interest payments and asset maturities (for example) arising from the asset portfolio. The ideal is to have an exact or near match of the two streams so that they compensate each other. If the streams are significantly mismatched, the insurer will experience cash flow problems in the future.

To correct a mismatched situation requires a reshuffling of assets, but this creates a new risk: finding an asset with equal or better returns and with similar quality. If an asset is traded for another asset, the investment yields assumed in the pricing must be retained.

Another risk related to longer-term products is the **reinvestment risk**. This arises when the insurer takes on a long-term liability or a fixed guarantee, but does not have assets with the required returns and equal durations to cover the guarantee.

For example, suppose a microinsurer promises a fixed endowment 20 years in the future and the actuary has assumed a 6 per cent interest rate over the entire 20-year period to determine the premium rate. If the microinsurer is limited, for example, to investing in five-year term deposits currently yielding marginally higher than 6 per cent, it faces a very significant pricing and reinvestment risk because of the uncertainty in reinvestment interest rates as the five-year term deposits mature. If five-year term deposit yields drop below 6 per cent in later years, the microinsurer could be wiped out, depending on the size of that portfolio and on the degree of mismatch. Even a few basis points can be devastating due to the effect of compounding interest. **The only sure way to manage this risk is to match interest rate guarantees (both interest amount and duration of the guarantee) with the available assets at the time that the guarantee is made.**

Recently, the Provident Fund of CARD MBA was prone to this risk because it had promised an 8 per cent return over 20 years to members on their Php 5 per week savings deposits. This guarantee was not covered appropriately because the organization was limited to short-term investments or investments in related organizations.

⁷ Increasingly, computer models are used to devise portfolios of assets most appropriate to anticipated payout needs. This enables a series of “what if” scenarios to be produced, contrasting the implications for various asset mixes and assumptions.

CARD's loan portfolio yielded a net rate of approximately 8 per cent in late 2003, after deducting 20 per cent investment tax and expenses. However, the risk was reduced because members dropping out of the scheme before three years of continuous membership forfeited their savings – the forfeited savings increased portfolio yield and this covered some of the mismatch risk. The danger was that the organization was not measuring the net degree of risk that it faced at the time (and will continue to face until the policies mature). The organization has since remedied this risk and is now advising members that interest credited will depend on the actual net investment yields.

Table 28 illustrates the potential effect when actual net yields are below 8 per cent. The illustration assumes that 100,000 members deposit Php 5 per week for 1,044 weeks (20 years) and then claim their deposits at the guaranteed 8 per cent per annum. The calculation also assumes that the forfeited savings of early drop-outs have been factored into the 20-year net yields.

Table 28 Potential effect of investment mismatch on CARD's Provident Fund – An illustration

Actual 20-year net yield (%)	Cumulative actual value (Php)	Cumulative actual payout (Php) at 8%	Cumulative shortfall (Php)	Cumulative shortfall (US\$)
8.00	1 241 123 685	1 241 123 685	0	0
7.90	1 226 889 442	1 241 123 685	(14 234 243)	(258 804)
7.80	1 212 836 564	1 241 123 685	(28 287 120)	(514 311)
7.70	1 198 962 701	1 241 123 685	(42 160 984)	(766 563)
7.60	1 185 265 529	1 241 123 685	(55 858 156)	(1 015 603)
7.50	1 171 742 756	1 241 123 685	(69 380 929)	(1 261 471)
7.40	1 158 392 119	1 241 123 685	(82 731 566)	(1 504 210)
7.30	1 145 211 384	1 241 123 685	(95 912 301)	(1 743 860)
7.20	1 132 198 345	1 241 123 685	(108 925 339)	(1 980 461)
7.10	1 119 350 826	1 241 123 685	(121 772 859)	(2 214 052)
7.00	1 106 666 676	1 241 123 685	(134 457 009)	(2 444 673)

Note: Php 55 = US\$1

6 Profit distribution

Most microinsurance programmes today are still too new to start distributing profits; in fact, many are still struggling to become viable. Others such as CARD MBA are not permitted to pay out dividends due to the legal restrictions of a mutual benefit association, even though they are in a financial position to pay back some of the accumulated profits over the years.

Before profits are distributed, a target should be set to maintain a certain level of contingency reserves. The level of this contingency or surplus should be based on the risk the insurer faces. For example, in health insurance, many organizations such as AssEF aim for six to nine months premiums as a contingency reserve.⁸ For credit insurance, the level of contingency reserves may be calculated using risk-based capital measures, i.e. a capital measure that links risk and capital adequacy, as practised by commercial insurance companies.

Some organizations have bylaws or are subject to legal requirements that determine profit distribution based on a prescribed formula. For example:

- La Equidad in Colombia complies with the cooperative law and allocates 20 per cent of profits to education, 10 per cent to its solidarity fund, 20 per cent to members' reserves, and 50 per cent to members' dividends based on premiums paid and claims paid.
- Spandana in India uses its profits to fund scholarships for its members' children.
- Yasiru in Sri Lanka distributes 40 per cent of its profits to members with at least five years of membership, 10 per cent to a welfare fund, and 50 per cent to a contingency fund.
- UMSFG in Guinea is building up reserves to a level of 75 per cent of prior year claims. Once this is attained, it plans to use surpluses to fund a health promotion campaign and improve health facilities.
- MUSCCO is considering profit distribution to SACCOs with good performance or claims experience. However, it will only be paid when a SACCO pays its premiums on time – one third of the SACCOs are behind with their premium payments.
- By law, 90 per cent of Delta Life's profits must be returned to its endowment policyholders and the remaining 10 per cent may be paid to shareholders. Microinsurance is no exception.

In the partner-agent model, the agent usually works on a commission basis, and the insurer's shareholders benefit from the company's overall performance. However, there is another way to structure the relationship. For example, the distribution channel could negotiate a surplus share with the insurer, as Pulse has done with Madison Insurance in Zambia. In this case, after paying claims, Madison deducts 30 per cent of the premiums for its expenses, and then shares the balance 50-50 with the microfinance institution. This approach seems to be more in line with the spirit of microinsurance

⁸ Other microinsurers target a contingency reserve based on the claims paid in the past 1,2,3,... x months.

since at least a portion of the surplus comes back to the community. It is also better risk-management practice for the insurer, since it gives the agent a financial incentive to produce a quality risk portfolio and not to be indifferent to adverse selection or fraud.

7

Conclusion

The main messages in this chapter are as follows:

- Sound financial management is one of the most important requirements for long-term success in the insurance business.
- Insurance is the business of risk management. The quantification of these risks, which should be done by an actuary, is the basis for determining the amount of reserves and capital required to sustain the scheme.
- For marketing purposes it makes sense to charge the same price for each client, at least for small policies; the applicable rate should be derived from the weighted average mortality or morbidity rates to take into consideration the actual age-sex demographic profile of the group.
- The objective of good investment management is to achieve a balance between risk and return, matching anticipated inflows from investments to expected outflows, while maintaining appropriate liquidity to meet obligations as they arise.
- Long-term products are vulnerable to reinvestment risk. To manage this risk, it is necessary to match interest rate guarantees (both in amount and duration) with the available assets at the time that the guarantee is made.
- Microinsurers should have investment policies and controls to ensure that the policies are implemented.
- Reinsurance cannot take a losing proposition and turn it into a viable entity. It is particularly appropriate for small risk pools and those with heterogeneous risks and irregular claims patterns; it is also extremely relevant for all microinsurance schemes, big and small, to cover catastrophe risk.
- Microinsurance programmes should aim to accumulate capital to manage risks, and only distribute profits or surplus once an actuary determines that the scheme has sufficient reserves.

Craig Churchill and Richard Leftley

The authors appreciate the feedback and suggestions from Toon Bullens (Interpolis), D'Arcy Delamere (CUMIS) and Zahid Qureshi (consultant).

Organization development is a planned effort to increase an organization's effectiveness by intervening in the operational processes. The organization development field, which emerged in the first half of the 20th century, has since evolved to sharpen its focus on change to emphasize the notion of a learning organization.

Warner Burke (1992) stresses that organization development is not just anything done to improve an organization, but a change process designed to bring about an intentional end result, requiring organizational reflection, system improvement, planning and self-analysis. Leadership theorist Warren Bennis (1993) describes organization development as a complex strategy to change the beliefs, attitudes, values and structure of organizations so that they can better adapt to new technologies, markets and challenges.

Indeed, such changes are required, in both insurers and delivery channels, if they wish to offer insurance to the poor effectively.

A basic measure of an organization's success is the extent to which it meets the changing needs of its clients and stakeholders. Service industries depend on the effectiveness of frontline staff who interact with, and are expected to provide value to, the customer. This is particularly true of insurance which, as an intangible service, is often not well regarded and understood. Microinsurance has an added complexity because there may be different levels of customers, such as the holder of a group policy and the end-users. Moreover, since the risk-carrier and the distributor can be different organizations, the insurer may have little or no control over the staff who interact with persons covered by a group policy.

The lack of control over frontline staff, coupled with a reluctant and uninformed market, necessitates some creativity in deploying, training and rewarding staff for delivering microinsurance. This chapter considers five aspects of organization development: 1) organizational structure, 2) recruitment, 3) training, 4) compensation and 5) institutional culture.

I Organizational structure: Where does microinsurance fit in?

Microinsurance is often just a small piece of a larger organization's business activities. In an insurance company, it may be a product line or even just a few policies. For organizations involved in distribution, such as microfinance institutions, microinsurance tends to be treated as an additional financial product, but one that has less importance than the organization's core savings and credit services.

The only exception to this general characterization is the community-based model (*Chapter 4.3*), the sole purpose of which is to provide microinsurance to a defined group. Perhaps if the market had more organizations that were only or primarily focused on providing microinsurance, greater energy and attention would have been harnessed for structural innovation.

For organizations that are only marginally involved in microinsurance, there are still some simple and clear lessons about how it can be structured within a larger organization – both the distribution channel and the insurance company – to achieve the best results.

I.1 Distribution channels

When considering the structure of microinsurance in a distribution channel such as an MFI, it is necessary to consider how it fits into both the front and back office structures.

Head office

To ensure that sufficient attention is given to microinsurance, distribution channels should have designated staff members or even a small department at head office to enable them to focus on insurance. Obviously, this will depend on the size of the organization and the functions that the distribution channel has assumed from the insurer. For example, if it is involved in claims processing, it will require more personnel. In general, however, when microinsurance is just a piece of someone else's job, it too often has a low priority.

In a distribution channel, a microinsurance department acts as a first line of response to queries from field staff and clients. It consolidates all premiums from the branches and arranges monthly payments to insurers. It acts as a filter for claims, by ensuring that they are valid and that the documentation is in order as claims pass through from the field to the insurance company. To simplify the administration, often the microinsurance department will hold insurance application forms and only submit them to the insurance company if there is a claim. The department also performs a vital record-keeping function and might therefore require a bookkeeper. In addition, the department

may need training specialists to provide field staff and clients with sufficient information and expertise.

At ASA in India, for example, of the 350 people that work for the MFI, seven work exclusively on its microinsurance activities. ASA needs this level of commitment because the MFI assumes responsibility for claims management. If a delivery agent anticipates trying to create a formal brokerage or even an insurance company in the future, then it would be wise to assume a greater role in the delivery of insurance, especially claims processing.

Besides having a dedicated microinsurance department, it is also essential to have a champion within the senior management team and on the board. While these persons are not involved in the day-to-day insurance operations, they can represent and promote the product in management and governance circles, giving insurance a voice at a strategic level in the organization. These champions should receive regular updates from the department handling the business.

Field structure

As for field operations, there are two main ways to structure responsibilities when insurance is not the organization's core business. The more common approach is to integrate insurance into the activities of the frontline staff, such as tellers and loan officers. When they are opening up savings accounts or marketing credit products, they could also encourage clients to buy insurance.

However, if the frontline operations become sufficiently large, the recruitment of an insurance specialist at the branch level may be justified. For example, when insurance operations in credit unions collaborating with TUW SKOK (Poland) and La Equidad (Colombia) generate a certain number of policies per year, they employ a credit union staff member to work exclusively on insurance. This person is trained to handle the more complicated questions and solve problems that typical frontline staff cannot handle. This arrangement tends to have a compounding effect on sales; premiums in credit unions with insurance specialists tend to grow faster than in those without specialists.

The choice between generalists and specialists in the field is not just a matter of scale. TSKI in the Philippines has over 150,000 borrowers, but it relies only on its loan officers to sell insurance. The other factor involved is the product type. If insurance is integrated into the distribution channel's other services, such as savings and credit, and is never offered on its own, the organization may not need an insurance specialist in the field.

Specialists are also appropriate if the insurance product is complex. For example, VimoSEWA (India), which offers a basket policy covering death, hospitalization and property loss, switched from general SEWA organizers to specialized staff to manage its annual mobilization campaign. These *Vimo Aagewans* are community leaders who are taught how to sell and service the insurance product. By specializing in insurance, *Vimo Aagewans* are expected to be more effective than generalists. Given the increase in volumes, higher retention rates and significant improvements in after-sales service in recent years, it appears that this switch is beginning to pay off despite the resultant higher distribution costs, although the data is not yet available to reach conclusions on whether this is an appropriate strategy.

1.2 Insurers

Insurance companies serving the low-income market might also want to consider creating a special unit concentrating on microinsurance. This focused effort will enable them to get a better understanding of the micro market and find creative ways to respond. This was not the arrangement at AIG Uganda, where no one had an overview of the insurer's relationships with MFIs, and there was no information about the contribution of the microinsurance policies to the company's profits. Consequently, there was little investment in the microinsurance product, hardly any innovation over six years, and a lack of training provided to the MFIs' employees.

In contrast, Tata-AIG created a special department for the Rural and Social Sector, with a budget and flexibility to act creatively, and a mandate from senior management. Perhaps the result of the unique regulation in India mandating entry into the low-income market, this arrangement allowed the insurer to experiment with products and delivery channels that may be more appropriate for the low-income market than the accidental death and disability cover provided by its sister organization in Uganda.

According to ICMIF (2005), the expansion strategies of Company 3 in the case study also illustrate the pitfalls of an inappropriate organizational structure (*see Box 51*). Serving middle- and low-income earners, its group life insurance showed early promise, but the company got into individual life insurance which is a significantly different product line. To deliver individual products, Company 3 created an organizational structure that it ultimately could not support.

Box 51

Organization development: How not to do it

Company 1 operates in a transition country with an annual net premium income of US\$3.5 million, 27 staff members and no service centres other than its head office. In the same country, **Company 2** has a net premium income of US\$5.8 million, 210 full-time employees plus 85 part-timers, and 23 regional offices with 32 sub-offices “for sales and loss adjusting”. **Company 3**, in a developing country, had (the past tense is no mistake) a net premium income of US\$2.8 million, a full-time staff of 705 plus 1,825 part-timers, and 58 service offices all over the country.

Even making allowances for the difference in products, market segments and geography, it is not hard to tell which insurer can look ahead to a stable future and which is likely to continue struggling, and why the third bit the dust. A basic, albeit rough, measure of productivity says it all: premium per employee. It is US\$129,629 for one and US\$19,661 for the other, and it was a mere US\$1,106 for the third. The one with the highest number of employees also, understandably, had the crippling overhead burden of the highest number of service outlets.

Company 3, the one with huge overheads that died before reaching maturity, wanted to be close to its customers spread across the country. So it put all the required functions – underwriting, claims settlement, premium collection and marketing – in each of its 58 service offices, without distinguishing between frontline and support services. Good for creating jobs, but temporary ones at best.

Source: Adapted from ICMIF, 2005.

2 Recruitment: Where to access appropriate expertise

2.1 Field staff

The screening and selection of frontline staff involved in distributing insurance usually depends on the criteria for their main responsibilities, such as granting loans. Rarely does the fact that they will also be involved in selling insurance affect the decision to employ them. However, the characteristics required to sell credit are somewhat different from selling insurance. When someone gets a loan, it is much more tangible – cash in hand – than the peace of mind and security associated with insurance.

As a result, the demand for loans is generally much higher than for insurance, so loan officers do not have to have the sales expertise that insurance requires. In addition, the poor understand credit better than insurance,

so there is less of a need to explain how it works. This requirement for client education calls for a different skill set from that which a typical loan officer may have.

If an organization is interested in recruiting people just to provide insurance, it might be useful to consider the selection criteria established by Tata-AIG for its micro-agents, who focus exclusively on insurance sales (*see Box 52*). Tata-AIG also involves non-governmental organizations (NGOs) in the process of identifying micro-agent candidates since locally they are often in a good position to assess the extent to which individuals are respected in their communities (*see Chapter 4.5*).

Box 52

Criteria in the selection of micro-agents at Tata-AIG

The criteria for the selection of a leader of a community rural insurance group (CRIG) include:

1. Must be a resident of the community in which she will sell and service policies.
2. Should preferably have passed the 12th school year or at least the 10th – this is to ensure that she is eligible to be licensed (an IRDA requirement).
3. Married: since microinsurance is a long-term commitment to policyholders, an unmarried CRIG leader may migrate to her (future) husband's village, leaving the CRIG and the policyholders in the lurch.
4. Ability to write English: since underwriting at head office is in English, it is imperative that the proposal forms are completed in English.
5. Good track record of integrity: handling money is an integral part of her duty as a leader.
6. Effective leadership qualities: she has to manage a group of four other women.
7. Public speaking ability: she will be required to address gatherings to promote the products.
8. Training skills: since she is the only one trained in insurance, she has to train the other four.
9. Must have a positive influence among the target market: each leader should be admired for her integrity and have a forward-looking and progressive nature, and must be able to use her influence to enable her CRIG members to achieve their targets.
10. Preferably, she should have some previous work experience in the social sector.

Source: Adapted from Roth and Athreya, 2005.

The agents for CARD MBA in the Philippines, called coordinators, are elected by the membership rather than being recruited by the institution (*see Box 53*). Similarly, the selection of frontline staff in the community-based model has the advantage of involving members directly in deciding who will manage the scheme. If this decision-making process is facilitated properly, members usually select someone they trust who has sufficient aptitude to learn the administrative responsibilities.

Where frontline staff do specialize in insurance, it may be useful to consider giving them more specialized responsibilities. For example, ServiPerú has some agents that focus on sales, and others that collect premiums and process claims. This separation of responsibilities is justified given the very different skills required for these functions.

Box 53

Frontline staff at CARD MBA

Frontline staff or coordinators at CARD MBA are members of the scheme, elected by their peers to fulfil a customer service function. Their activities include claims verification and payment, educating current and potential clients and addressing questions from CARD's staff or clients. They also work with branch managers to ensure timely collection and transfer of premiums as well as document compliance.

According to the MBA's immediate past president and former coordinator Pilar Garcia, a coordinator's tasks are delegated to trusted members with good standing at CARD. Coordinators commit to working at least one day per week on MBA business, although the responsibilities often demand more time. The work involves irregular hours, as claims verification must be done immediately to ensure that settlements are processed in three days.

People are selected to be coordinators for a one-year term. Although this short period requires a lot of training, the term limit reduces fraud since it does not allow coordinators time to get too clever. Perhaps more importantly, by involving many members in the insurance operations, it generates more knowledgeable policyholders, improving their effectiveness in MBA governance.

New coordinators undergo a day's training at the March annual membership convention; in the period between their election (in December or January) and the training, they perform their duties in cooperation with, and under the supervision of, the outgoing MBA coordinator for their region. The bulk of the training occurs on the job, which is possible because the business processes and products in the MBA are simplified.

Source: Adapted from McCord and Buczkowski, 2004.

2.2 Back-office staff

As for management and back-office staff, given that microinsurance is a new field, insurers and their distribution channels are unlikely to find too many existing microinsurance specialists. So organizations can act in one of two ways: either they can recruit intelligent people with development experience and teach them about insurance or they can employ insurance specialists and help them understand the low-income market.

Delta Life (Bangladesh) and Tata-AIG both took the first approach, staffing their initial microinsurance operations with social-sector specialists since the organizations already had insurance expertise. In both cases, the organizations realized that they needed new thinking to overcome the obstacles to extending insurance to the poor, which was not likely to come from traditional insurers. CARD MBA, on the other hand, needed to hire insurance expertise to solve the problems that were created when microfinance specialists were running the insurance operations. SEWA essentially adopted both approaches, handing the reins of VimoSEWA to a long-time SEWA manager, but recruiting someone from the insurance industry as Chief Operating Officer.

Of course, microinsurers do not have to have all of the expertise in-house as long as they can access it. In fact, many conventional insurance companies do not have in-house actuaries, but rely on actuarial consultants. TUW SKOK, for example, used an actuarial consultant for years. When it was granted a licence to start a life insurance company along with its general insurance company, the organization felt that it had sufficient need for actuarial services to employ an actuary; yet at the same time, it decided to outsource its investment management since life insurance investments required greater expertise than it had in-house (*see Box 54*).

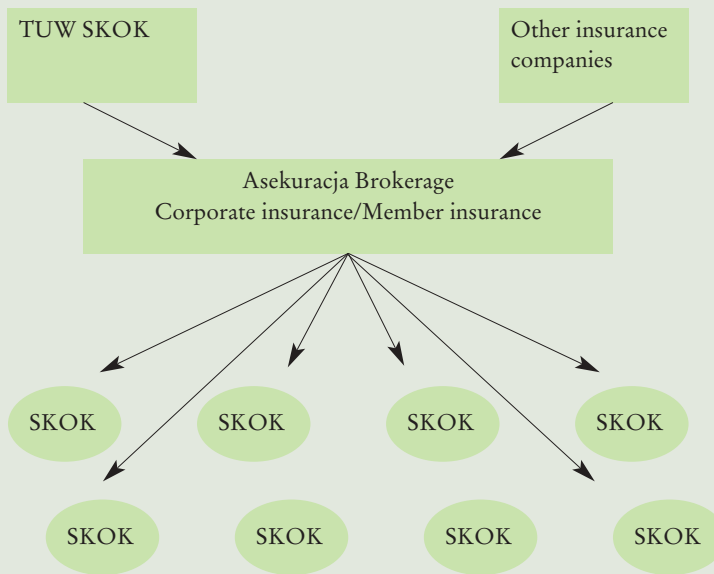
It may not be possible or cost-effective for each microinsurance provider to retain full-time experts. However, identifying suitable sources of expertise in the areas of product design, client-needs analysis, processes mapping, product costing, distribution, reinsurance and actuarial support would be prudent prior to launching a new microinsurance venture.

Box 54

TUW SKOK's outsourcing model

TUW SKOK's structure is largely organized around an outsourcing model. The central agency in this model is Asekuracja, a brokerage company owned by TUW SKOK, the National Association of Credit Unions (NACSCU) and the Foundation for Polish Credit Unions. The brokerage serves as the link between the credit unions (SKOKs) and insurance companies, including but not limited to TUW SKOK. Where possible, the insurance provided by

the brokerage to credit unions comes from TUW SKOK, but as the insurer is not licensed to offer all types of insurance, the brokerage will go to the open market if TUW SKOK does not offer the required product and issue a tender for services to several insurance companies.



This arrangement allows the SKOKs to offer products, such as car insurance, for which TUW SKOK is not licensed. Besides the relationship with the brokerage, TUW SKOK outsources other key activities:

- *Market research*: TUW SKOK undertakes modest market research activities in-house, but it outsources larger studies to a market research firm.
- *Actuarial services*: When it was a relatively small insurer, TUW SKOK contracted an actuarial consultant for a few days a month. With the recent purchase of the life insurance company, the business has grown to a sufficient size to justify recruiting an in-house actuary.
- *Software development*: TUW SKOK is part-owner of the software firm that develops the MIS for the credit unions. H&S Software, housed in the same building as TUW SKOK, NACSCU and the Foundation, also develops some of the software used by the insurance company.
- *Sales*: Besides the corporate sales outsourced to the brokerage firm, TUW SKOK (via Asekuracja) outsources the retail sales activities to credit unions and their staff.

- *Claims adjusting*: For its property insurance policies, TUW SKOK relies on independent claims adjusters to assess and document the damage. For disability products, the insurer also has a list of medical doctors whom it trusts to determine the degree of disability.

Source: Adapted from Churchill and Pepler, 2004.

3

Training

Since organizations are unlikely to be able to recruit people with microinsurance experience, they need to compensate by making significant investments in staff training. However, this is not borne out by experience in the field thus far. The case studies show that staff training remains one of the greatest areas for improvement.

One of the main causes of the problem is the prevalence of mandatory products. Where insurance is compulsory, training is largely overlooked or limited to basic product issues. This experience was most clearly seen when FINCA and AIG Uganda switched from voluntary to mandatory insurance, and soon after neither staff nor clients had a particularly good idea of the costs, benefits or claims procedures (McCord et al., 2000).

Even when the product is voluntary, many microinsurance providers admit that the training of frontline staff is one of their most significant challenges. At Delta Life, for example, microinsurance salespersons learn on the job, without any formal training. TUW SKOK, Columna (Guatemala) and La Equidad all try to train the credit union staff, but high turnover undermines their efforts. To overcome this problem, TUW SKOK has set up regional offices that are primarily responsible for providing training, usually in the evenings or weekends when credit union staff are not busy with their primary responsibilities.

VimoSEWA is taking the training challenge seriously. With the assistance of an outside expert, it has developed training plans for each staff member. The process was to document existing skills and those which were lacking, and then prioritize the needs of each individual. The *Vimo Aagewans* had particular emphasis placed on product knowledge, claims processing and sales skills.

In general, training for frontline personnel should include:

- basics of insurance, providing staff with the ability to answer difficult questions;
- specifics of the products' policies and procedures;

- details of the pilot test results (for new products);
- familiarity with the operations manual;
- strategies for adult education, including how to use educational tools;
- demonstrations on how to use marketing materials, such as pamphlets and posters;
- role-play exercises enabling staff to make mistakes in the classroom rather than in front of clients;
- customer-service training and
- an examination to ensure that a level of understanding has been achieved and to identify those that require re-training.

It is important that insurance training is not limited to frontline personnel. For example, before launching a pilot test, Opportunity International provides loan officers, supervisors, branch accountants, branch managers, MIS operators and heads of department with a one-day course covering the basics of insurance, answers to frequently asked questions (FAQs) and specifics of how the new product will perform. Since microinsurance is a new field, international exposure for managers and directors is also advantageous as it enables them to share experiences with others involved in similar schemes.

Lastly, training is not a one-off phenomenon. Microinsurers should regularly upgrade staff skills with the intention of creating a career path that will enhance staff retention.

4 Compensation

The staff turnover problem identified above is largely associated with compensation. For microinsurance to be affordable for the low-income market, costs have to be low. Yet labour-intensive delivery systems that manage large volumes of small transactions can easily become expensive. Consequently, microinsurers try to keep staff costs as low as possible (*see Table 29*), which may result in high turnover and low productivity.

Table 29

Average monthly earnings for frontline staff (US\$)*

<i>Microinsurer (Country)</i>	<i>Agent's average monthly earnings</i>
Delta Life (Bangladesh)	16
UMSGF (Guinea)	7
VimoSEWA (India)	38
Tata-AIG (India)	15
CARD MBA (Philippines)	11

**Note: These agents often only work with insurance on a part-time basis.*

Indeed, one of the more interesting questions about microinsurance revolves around appropriate compensation mechanisms for field staff and agents. For voluntary insurance, how does an insurer reward sales to achieve greater outreach and impact without pushing insurance onto poor people? Delta Life recognized this problem and initially created a stepped salary structure based on monthly premiums (average for the previous quarter). Its incremental rather than linear incentive system was intended to reward good performers without creating a strong pressure to sell. Yet today, after a period of poor sales, Delta's management is experimenting with a commission-only approach used by the conventional insurance scheme to boost penetration.

As discussed in Chapter 3.2, there will always be a danger that remunerating people to sell voluntary insurance will cause them to sell products that people do not really need. However, the danger of not compensating field staff adequately is that they will either not sell the product, or they will minimize their efforts, leading to ill-informed or misled clients. The remuneration should motivate sales and provide customer service. To ensure that policies are not mis-sold, management should regularly interview clients as part of its market research or needs analysis programme to assess their understanding.

A related issue is who should receive the incentive – the delivery channel or field staff (or some combination)? Where insurance is mandatory, it does not make sense to reward individual agents, but the situation is different with voluntary products. For example, since TUW SKOK is not in a position to force credit unions or their staff to do anything, its primary means of influencing performance is through incentives. With different products, the insurer has tried different means of structuring commissions to reward credit unions and agents. Although there is not yet sufficient evidence to assess which combination of incentives is most effective, TUW SKOK is tilting the incentives more towards credit unions than individual agents to garner

greater management support for insurance sales.¹ In contrast, La Equidad is achieving greater market penetration when agents, and not just the credit union, receive a commission. Yasiru in Sri Lanka pays a commission of 25 per cent of the premiums, 10 per cent to the organization and 15 per cent to the field agent.

With long-term insurance products, commissions are often frontloaded. For example, ALMAO in Sri Lanka uses the official, regulator-approved commission structure for long-term insurance (*see Table 30*). With such an incentive structure, there is a danger that the retention rate for microinsurance will go down when the agent's commission is reduced. When the agent earns three to six times more to enrol a new client, it will be much more attractive to sign up new members instead of collecting premiums from the old ones.

Table 30

Commissions (% of premiums) on long-term policies at ALMAO and Tata-AIG

<i>Policy year</i>	<i>ALMAO</i>	<i>Tata-AIG</i>
1	30	26 to 30
2	20	5.5 to 6
3	15	5.5 to 6
4	10	4 to 5
5 to 10	5	4 to 5

Tata-AIG has a similar declining incentive structure.² Such commission structures may make sense when the work is frontloaded, which is the case when premiums are paid through electronic transfers in the banking system. With mainstream products, after year three, most clients in India pay premiums directly to the insurance companies, not via the agent. However, when agents are manually collecting premiums and the workload is therefore spread more evenly throughout the policy term, a more even distribution of commissions would also be appropriate. Consequently, Tata-AIG is trying to get the Indian regulator to agree a flat commission structure for its agents to reward ongoing service, not just sales.

In contrast, ServiPerú offers health and life insurance on a one-month, renewable basis. Salespersons earn a commission during the first three months of a policy at the following rates: 56 per cent in the first month, 28 per cent in the second month, and 42 per cent in the third month. The commission in the

¹ TUV SKOK has introduced additional commissions for achieving volume thresholds. When a credit union sells 1,000 policies, the brokerage firm pays it a bonus of US\$1,200.

² In addition, Tata-AIG pays a bonus of Rs. 10,000 (US\$222) to CRIGs that build a client base of 600 policies; there is no time limit for achieving this goal.

third month is higher than in the second month to create an incentive for agents to encourage clients to budget accordingly. After the third month, there are no further commission payments to the sales agent. This is possible because of the separation of responsibilities between sales and premium collection. Seventy per cent of the premiums are collected door-to-door, not by the sales agent, but by a premium collector.

In general, since the sums insured are very small, it is difficult for commission amounts to be large enough to influence agent behaviour. The commission of 10 to 20 per cent, which is the typical range, amounts to relatively little for microinsurance agents. Other techniques are therefore also required to motivate sales. For example, Tata-AIG organizes an annual conference and invites its most successful micro-agents. The insurer also has contests from time to time to enhance persistency and stimulate new business, such as the one depicted in Figure 19. To stimulate competition among its agents, TUW SKOK rewards the top 20 salespersons with a trip to Rome or Paris for two (thus also rewarding spouses or partners for their support and sacrifice).

In designing microinsurance compensation, it is useful to consider a **differentiated approach**. The salary structure at Grameen Kalyan is based on the distance of the work place from the capital city – the more remote the area, the higher the salary – encouraging people to work in rural areas. In contrast, VimoSEWA recruits its *Vimo Aagewans* to work near their residence and pays more to urban than rural promoters because of the higher cost of living. At ServiPerú, agents are classified into four categories depending on how long they have been with the organization and their sales record: New Executives, Junior Executives, Master Executives and Premium Executives. The basic monthly salary varies according to category; Premium Executives earn more than Master Executives, etc. Each category has a different minimum number of plans to sell each month: the higher the category the greater the target.

From ServiPerú's experience, setting customized targets for each salesperson is an appropriate way to control exaggerated enthusiasm for sales, achieving a manageable growth pattern. VimoSEWA plans to experiment with incentive compensation based on the renewal ratio, sales targets and the number of family packages sold. Indeed, incentives that reward client retention and persistence are likely to be more appropriate for microinsurance than incentives strongly linked to sales.

Figure 19 Kharif Hungama sales prizes

Kharif HUNGAMA

Scheme Period: 10th June to 10th September 2005

Scheme for Specified Persons & Agents

No. of Issued Policies		Prize		
From	To	Option 1	Option 2	Option 3
Upto 30		Umbrella	Table Clock	T shirt
31	75	Foldable Travel Bag	Calculator	Beete Phone Instrument
76	125	Wall Clock	Stainless Steel Utensils	Iron
126	200	Melaware dinner set	Gents SunGlasses	2 Chargeable Battery Lights
201	500	Gold Coin	Radio	Chargeable Battery cum Fan cum Radio

Only issued policies with quarterly or semi annual or annual mode of payment will be considered during the scheme period.

• Qualification can be only in the categories as mentioned above • No cash will be given in lieu of prizes • All prizes will be given only on basis of Issued Policies
 • Prizes that expire and are cancelled during the free-look period will not be considered • Queries with regard to qualification must be brought to the notice of the
 Distribution Operations - HQ within 10 days from announcement of final qualification • Only this scheme is valid for the period mentioned above • Any other
 programme launched for the period stands null and void • TATA AIG Life's decision will be final and binding
 All rewards are indication. Actual prizes will be subject to availability.

For details visit website or call 1800-102-0202. Insurance is the subject matter of microinsurance.

TATA AIG LIFE | A new look at life

5

Institutional culture

Although microinsurance has to abide by the same basic principles as traditional insurance, it needs to do so with a keen appreciation for the unique characteristics of its target market, in particular the reluctance of low-income households to spend their very limited resources on something that lacks a tangible benefit. The culture of a microinsurer has to marry a social concern with an appreciation for the bottom line.

Any organization that strives to serve both the poor and mainstream markets will need to take positive action to ensure that its field staff are actively serving the poorer segments. Incentives based on sales volume will always reward those that sell larger-value policies, so staff will be tempted to sell fewer, larger policies rather than many small policies. One way to overcome this is to separate the sales forces, with different standards and reward systems for different market segments. The means of distribution will also differ, with poorer clients requiring more frequent field visits, and wealthier segments requiring fewer but longer contacts, typically in an office setting. Combining service for the poor with serving the not-so-poor will be difficult unless the board and management are fully committed to serving the low-income market.

This hybrid of insurance and social development was clearly recognized at Delta Life, which sought to create a distinct culture for its microinsurance activities. It completely separated the microinsurance and Ordinary Life staff, both in the field and in the head office, to create distinct working environments. A key reflection of the different cultures is evident in the responsibilities of field staff. Microinsurance field workers, known as “organizers”, manage the entire relationship with the policyholder, including premium collection, loans and loan repayments and claims, whereas Ordinary Life agents, working on a commission basis, fulfil primarily a sales function.

Other manifestations of a microinsurance culture include:

- **Relationship building:** Microinsurance requires field staff to focus more on building a relationship than making a sale. Delta and VimoSEWA have structured their activities so that agents are responsible for sales as well as service. This emphasis can be reinforced through retention-based incentives.
- **After-sales service:** VimoSEWA emphasizes after-sales service, ensuring that members know what is covered and receive any assistance they require in preparing claims documents. The higher costs of these activities are expected to be offset by enhanced customer retention.

- **Claims processing:** Many conventional insurers find ways to discourage policyholders from submitting smaller, so-called nuisance claims, by specifying exclusions, including deductibles, making claims documentation difficult, charging a claims service fee or imposing a graduated increase in premiums for the number of claims made. In microinsurance, providers have to enhance the market's trust of insurance by minimizing exclusions, making it easy to submit valid claims and even seeking out beneficiaries who may not have realized that they can claim.
- **Claims rejections:** Microinsurers need to minimize the likelihood of claims rejection. If VimoSEWA's insurance partners reject a claim that it feels should be paid, it assumes the liability for these extra-contractual claims. If claims have to be rejected, microinsurers need to find a way of communicating that result in a way that makes the decision acceptable to the claimant. For example, to lessen the impact of a rejected claim, VimoSEWA may send out head office staff members to explain the reasons for rejection to the members and to the community, while trying to strengthen trust and confidence in the scheme.

Perhaps this microinsurance culture is easier to create in a mutual insurance company or a community-based scheme than in a private, for-profit company. By definition, member-owned schemes are intended to maximize member benefits rather than shareholder profits, and are therefore more likely to go to greater lengths to provide appropriate microinsurance service. Plus, any profits that are generated are returned directly or indirectly to policyholders.

6 Conclusions

For microinsurance to provide more people with better services over the long term, current and future risk carriers and delivery channels will need to consider their beliefs, attitudes, values and structure. Given the current dearth of good practices, there appears to be significant room for improvement in this area. The organization development of microinsurance is a high priority, and should take into consideration the following lessons:

- Microinsurance requires its own space in the organizational structure of both risk carriers and distribution channels to ensure that there are people who are committed to making it work better.
- Commitment from senior management and the board is instrumental to the success of microinsurance.

- Outsourcing can be an effective way of accessing (micro) insurance expertise.
- For both insurers and distribution channels, when introducing microinsurance, consider the implications it might have on existing job descriptions and recruitment criteria.
- A greater emphasis must be placed on staff training, particularly for field staff. One way of testing the effectiveness of the training is to independently assess the clients' knowledge of insurance and the products after interacting with the staff.
- Compensation and incentives that reward client retention are likely to be more appropriate for microinsurance than incentives strongly linked to sales.
- A microinsurance culture has to take into consideration the characteristics of its target market. It should strongly emphasize relationship-building and after-sales service, while ensuring the organization minimizes claims delays and rejections.

3.8

Governance

Zahid Qureshi

The author would like to thank Hans Dahlberg (ICMIF), Klaus Fischer (Laval University), Augustine Hatch and John Pott (Aga Khan Agency for Microfinance), and Frank Lowery (The Co-operators Group) for reviewing this chapter and providing insights and details that added depth and value to this look at corporate governance in microinsurance.

Governance is the act of planning, influencing and monitoring, through policy, the affairs and direction of an entity. It involves systems and processes ensuring accountability and openness in the conduct of its business, whether the entity is a country, community, corporation or another organization. Governance involves the exercise of power and decision-making that reflects the interests of those who have a stake in the entity and those with whom the entity interacts or over whom it may exert influence.

At the organizational level, governance refers to the actions of its board of directors – the official group of persons, elected or nominated, who set and oversee the long-term direction of the organization. Like other enterprises, microinsurance schemes will not fully succeed without good governance. However, good governance for microinsurance providers is hard to come by, and it will be achieved in different ways depending on their ownership structure.

This chapter begins by introducing the concept of governance in general, and describing its unique characteristics in the context of microinsurance. It then covers the important issues of composition and expertise of the board. The bulk of the chapter describes five case studies that illustrate lessons for microinsurance governance.

I Governance in microinsurance

Is there anything singular or special about governance of an organization involved in microinsurance? The answer is yes and no. No, because corporate governance, like management, has core principles and objectives that would apply for a multinational corporation or a community-based organization (see Box 55).

Box 55

What is corporate governance?

Corporate governance involves a set of relationships between a company's management, its board, its shareholders and other stakeholders. Corporate governance also provides the structure through which the objectives of the company are set, and the means of attaining those objectives and monitoring performance are determined. Good corporate governance should provide proper incentives for the board and management to pursue objectives that are in the interests of the company and its shareholders and should facilitate effective monitoring. In addition, factors such as business ethics and corporate awareness of the environmental and societal interests of the communities in which a company operates can also have an impact on its reputation and its long-term success.

Source: Adapted from OECD, 2004.

And no again, because governance of both mainstream insurers and microinsurers involves corporate social responsibility (CSR) in addition to commercial objectives. Few annual reports these days neglect to tout CSR and an earnest pursuit of a triple bottom line, benefiting the consumer and community as well as the shareholder.

Yet microinsurance governance is different because the microinsurer cannot just dispense with its CSR by a do-good programme or project on the side. Microinsurance has CSR at its core, and its board of directors must ensure that a social or development perspective is coupled with commercial objectives to sustain the organization. Social protection, as the other face of microinsurance (*see Chapter 1.1*), is ever-present and cannot be put away for occasional attention.

The United Nations Conference on Trade and Development (UNCTAD), in its study "Selected Issues in Corporate Governance", draws the main elements of governance from several definitions. From the financial perspective, a fundamental of corporate governance is that it must assure an adequate return on investment to the suppliers of capital. More capital will flow to the company to help it grow to its potential if its governance mechanisms produce a good return for investors. This definition, applied to microinsurance, must encompass not just the financial returns on investment, but also the social returns. Indeed, the suppliers of capital for microinsurance schemes, including the policyholders in cooperative and mutual schemes, want to see evidence that such a scheme enables poor households to be less vulnerable.

Perhaps another way of defining governance is to consider the **mandate** of the board, which is responsible for guiding the institution in fulfilling its corporate mission, for protecting the institution's assets over time, and for ensuring that it respects the laws, rules and regulations pertaining to the type of business it transacts. The board sets the strategic direction of the organization, ensures that it complies with all legal and regulatory requirements (including any industry codes of practice to which it subscribes), and carries out a fiduciary or stewardship function to guard the institution's assets. In achieving that mandate, a microinsurer's governing body would not steer and direct it effectively without being mindful of the universal prerequisites of governance (*see Box 56*).

Box 56

The four pillars of governance

1. **Accountability**, or the capacity to call officials to account for their actions.
2. **Transparency**, entailing low-cost access to relevant and material information.
3. **Predictability**, resulting primarily from laws and regulations that are clear, known in advance and uniformly and effectively enforced.
4. **Participation**, needed to obtain reliable information and to serve as a reality check and watchdog for both government and corporate action.

Source: Adapted from ADB, 1997.

One of the great challenges of governance is understanding the **boundary between management and supervision**. The board provides the strategic direction; management is responsible for implementing a programme of activities to achieve that direction. In practice, however, the distinction between management and governance often gets blurred, to the detriment of successful operations – usually with some board members crossing the line into the management's area of responsibility or management pursuing a strategic course without the board's knowledge or approval.

2 Board composition and expertise

Another distinct feature of microinsurance governance is that it can take place within a range of different institutional and delivery models, as described in Part 4 of this book. Each model has specific governance challenges, particularly with regard to the composition and expertise of the board.

Corporate insurers that are going downmarket to serve low-income households – either on their own or in partnership with delivery channels – are likely to be entering uncharted waters. Invariably, the effectiveness of a board depends on the mix of individual directors, their experiences, risk appetite, causes and agendas. The chair and the chief executive should jointly ensure that officials nominated to the board have expertise that will complement rather than duplicate that of other directors, and will be appropriate given the direction of the organization. For example, if microinsurance is an important strategic direction, the board will need guidance to respond to the special needs and buying behaviour of the low-income market and someone who can have an effective voice on the board to balance the insurer's natural commercial orientation.

Cooperative, mutual or other popularly based microinsurers have an advantage over corporate insurers because they are closer to and more familiar with, and often themselves are, the target market. However, their natural social focus must be balanced with a commercial orientation. Development experts who have helped establish popularly based insurance programmes in a number of countries over the years identify **leadership training** as a key factor. This is a euphemism for two “room for improvement” items that they find among many organizers and elected officials of grassroots financial service providers:

- a) technical understanding, and
- b) grasp of a board member's responsibilities.

Except for those elected or selected by virtue of education and experience in financial services, board members of popularly based organizations have no more than a cursory knowledge of insurance. They display leadership too, but it is driven more by a populist cause or belief than by an in-depth knowledge of financial services.

Not having the proper mix of skills and expertise on the board is not only hazardous for an organization but potentially fatal. Many popularly based organizations, among them financial cooperatives, have struggled and gone under because of a lack of the required skills in the people running them. Their managers were not up to par on technical elements of the business and elected officials on the board were high on ideology, but had no more than a modicum of business acumen.

Even when in some cases the board had the foresight to hire a technically qualified manager, it tended to put him or her on a short leash, with frequent conflicts leading, before long, to the manager's resignation or dismissal (*see ICMIF, 2005*).

Even though the governance challenges for corporate and popular microinsurance organizations appear quite different, they have three key issues in common. First, to succeed, an enterprise needs a **champion**. Each board of directors involved in microinsurance can use at least one such entrepreneur as a member – this is particularly an issue where microinsurance is just one product or set of activities in which the organization is involved. These boards also need others who can complement the champion’s advocacy of the cause with a good understanding of the business and their own responsibilities.

Second, **external directors** can bring expertise that a board may be lacking. This is particularly relevant if microinsurance is quite different from the organization’s core services, or the target market is quite different. An external independent director does not represent any particular shareholder, but rather has relevant experience and skills to help shape the board’s guidance. In situations where the legal or corporate structure does not allow for external directors, this function could be addressed through an advisory committee.

Third, board members need to know what they are supposed to do. While this seems obvious, not all directors are aware of their responsibilities and how they should be carrying these out. Intensive training of new directors, with regular updates on governance issues, is essential. A good starting point is a “**job description**” (*Box 57*).

Box 57

Responsibilities of the board of directors

- To establish and review the aims and long-term objectives of the organization;
- With the recommendation and participation of management, to develop policies and plans whose implementation will establish the basic character and direction of the organization;
- To ensure the development, review, approval and evaluation of the corporate planning process;
- To maintain the continuity of a viable organization that delivers needed products and services to members and policyholders, and is managed in their best interests;
- To ensure adequate representation with and involvement of sponsors and other appropriate organizations;
- To oversee the management’s role in ensuring compliance with the governing statutes and by-laws;

- To delegate specific aspects of decision-making to board committees; and
- To ensure the continuity of management.

Source: Adapted from Co-operators Group, 2005.

For example, not all board members may be aware that their position entails **legal responsibilities** and obligations to govern, that they may be held liable for misusing or neglecting their legal duties, and that they have to declare a conflict of interest if they (or relatives, business associates or friends) stand to benefit financially directly or indirectly from any decisions or actions. Decisions regarding the awarding of contracts to third parties must be taken objectively and at arm's length – and be perceived as such.

Besides being mindful of their own conflicts of interest, board members need to attend to **relationships with external agencies**, including supervisory, government and industry bodies and associations. They need to take into account the effects of decisions or proposals on customers, suppliers, advisers and members of the public, because corporate governance must also be concerned with impacts outside the company.

Recent scandals involving boards of directors of some major corporations have spotlighted the role of auditors. Where external auditors are engaged, they may need to meet the board of directors in the absence of management. In many jurisdictions, auditors now have a legal duty to directly inform relevant authorities of malpractice or failure to respect good corporate governance principles.

Board members are expected to attend meetings regularly and review and question the reports and correspondence provided. The chair should ensure that management distributes agendas and operational reports in good time to directors to help make their meetings productive. Formal minutes of items discussed and decisions taken should also be distributed.

3

The foundation stone

For those instances where the vehicle for the microinsurance operation is a joint stock company, the Memorandum and Articles of Association of the company are the critically important foundation stone of good governance. They are sometimes referred to as the company's "Initiating Documents". With some modification, they should be mirrored in other governance structures such as cooperatives, mutual societies and NGOs. They are often accompanied by, and refer to, a Shareholder's Agreement, which may have to be revised when a significant shareholder either disposes of or acquires capital in the company.

These documents establish the intent of the initial providers of capital to a company and cover a number of important points with regard to how the company operates. In particular, the documents differentiate between, and prescribe the limits on, the powers of management and the powers of the directors – with the ultimate power lying with the shareholders and owners of the company. They thus establish three tiers of operational control: management, directors and shareholders (principal stakeholders).

They very clearly prescribe the following:

1. The areas of business in which the company is expected to operate.
2. The uses to which the capital of the company may be put.
3. The procedures for appointing (and dismissing) management (usually just the managing director or chief executive, but possibly also the chief financial officer and others) and the decisions that management is allowed to take without reference to the board of directors. The annual budget is usually an important tool by which directors control management's use of the company's money.
4. The procedures for the appointment of members of the board of directors (as well as dismissal procedures). Generally, these days a number of directors are appointed who do not represent the shareholders, and these directors are expected to represent the interests of non-represented stakeholders at board meetings as well as the interests of the public and the economy in general. The appointment of a director usually requires approval by a majority of the shareholders at a formal shareholders' meeting. The maximum and minimum numbers of directors allowed are also specified.
5. The powers the board of directors is allowed to exercise without reference to a meeting of the shareholders. Usually, the board exercises almost total control over the company's use of existing funds and assets, as well as the use of revenues coming in from operations. However, it has to refer to the shareholders with regard to new money coming into the company, in particular if it relates to any change in the percentage shareholdings and/or if it exceeds the prudential norms (described in point 7) for borrowing or otherwise putting the shareholders' capital at risk.

6. The way the directors' votes are used to make a decision (e.g. on some decisions unanimity is required but for others just a majority vote).
7. The financial prudential norms (i.e. financial limits) within which the company must operate, including borrowing limits, solvency ratios, exposure to certain coverage risks, reinsurance, and capital adequacy. These may also be prescribed by the government's appointed regulator (e.g. superintendent of insurance), but there is nothing to prevent the company from having norms that are more conservative.
8. The procedures for shareholders entering and leaving the company.
9. The procedures for shareholders exercising their votes to make a decision entrusted to them. Often a 75 per cent majority is required.
10. The decisions over which the shareholders have control are:
 - any change to the nine points above covered by the Memorandum and Articles of Association of a company,
 - the sale, liquidation or disposal of the company and
 - the appointment of auditors.

The Initiating Documents are, therefore, the reference by which the company is governed. It is particularly important in empowering both directors and shareholders if management (which may have little financial stake in the company) deviates from what the owners originally wished. The owners (shareholders) may, however, amend anything prescribed in these initiating documents, as mentioned in point 10, if they are persuaded to do so by either management or the directors. In this way the Initiating Documents are a foundation stone for company governance, but can still be modified with time as the company and its environment evolve.

4 Microinsurance governance in practice

To illustrate some of the governance issues faced by microinsurers in different institutional categories, here is a look at five cases.

4.1 Step ahead – if groundwork points the way

Delta Life, founded in 1986 to provide endowment insurance to Bangladesh's middle and upper classes, launched Grameen Bima (village insurance) two years later to enter the low-income market in collaboration with a microcredit NGO. Delta underwrote a scaled-down endowment product and the NGO delivered it to the poor along with its loans. The partnership soon dissolved because NGO staff members were more interested in selling their own loans than Delta's insurance.

Delta then developed its own delivery network and did well selling insurance directly. In 1991, it added microenterprise or project loans to its product menu, with its agents offering credit as well as insurance, and collecting repayment instalments as well as premiums.

In 1993, Delta launched Gono (urban) Bima for the poor in cities. Together, the two microinsurance schemes grew by leaps and bounds – a 1,025 per cent increase in new policies from 40,000 in 1994 to 450,000 in 1998. In insurance, growth of this magnitude, unsupported by a proportionate growth in equity capital and retained earnings, always spells trouble. And it did for Delta, revealing major problems – in information systems, internal controls and administration. In addition, bad debts had mounted with the exponential growth, as agents had been using loans as a marketing tool: buy a policy, get a loan.

In 2002-2003, Delta took decisive corrective action, including consolidating microinsurance under a single Gono-Grameen Bima division and eliminating the project loans. These and a number of other adjustments resulted in clear benefits for the company and its roughly one million poor customers.

If Delta Life's milestone decisions and actions were ascribed to appropriate structural components, this recap would say that Delta's board of directors decided to launch Grameen Bima and the partnership with the NGO. Later, too, the decision to end the partnership and choices of subsequent courses of action were made by the board of directors.

Management had a role to play as well, but mostly in researching available options and preparing briefs to help the board analyse and assess them, and then carrying out and following up on the strategic decisions. Indeed, since management was part of the problem, the 2002-2003 restructuring was led by a consultant who was hired by and reported to the board.

The board of directors was ultimately responsible and accountable for the direction Delta Life took and its consequences, as it had been in favour of launching the venture and starting and ending the partnership with the NGO.

The board's role, in a word, is stewardship – and that is the case in all jurisdictions.

How did Delta's board fare in its stewardship of the company? The case study concludes: "Over the years, Delta Life's social motivation has evolved into a commercial motivation, benefiting the company as well as its...customers. Along the way, Delta Life has learnt a number of valuable lessons, many of them the hard way." The study then lists several institutional lessons, including:

- Cross-subsidize start-up of microinsurance
- Manage microinsurance with the same business approach as traditional insurance
- Focus on core competencies
- Develop a good management information system for large volumes of small policies
- Establish internal controls, for where money is involved fraud will not be too far behind (*see Box 58*)

One underpinning lesson the case study, not to mention Delta Life itself, could have drawn is that the board of directors could have done its homework better – including the competence to understand that growth must not be out of proportion to the increase in the company's financial strength. Perhaps, if it had not had 36 members, the board might have been more effective. Indeed, Delta Life could have avoided chalking up lessons the hard way. For starters, solid research and careful analysis of the buying behaviour of the client base, and of the marketing approach of the microcredit NGO as the intended delivery channel, could have averted the first error – a partnership destined for dissolution.

Box 58

Trust is good, but control is better

After Enron, WorldCom and Parmalat, it was not the role of external auditors alone that came under the spotlight. Internal auditors were also mobilized. The global Institute of Internal Auditors based in Florida, United States, for example, has been focusing on how its members can better support compliance with corporate governance standards. Insurers in their formative years may not be able to afford an internal audit unit, but it would serve their boards well to direct management to assign that responsibility to a suitable staff member who can then work closely with the board's audit committee. Credit unions have a time-honoured structure ensuring not only democratic participation but also control through their boards and committees, and other popularly based financial service providers would do well to adapt it.

The point to keep in mind, however, is that there have been a number of instances where credit unions have encountered serious financial difficulties, which, almost invariably, have been due to the failure of good supervision and undue trust placed in key senior (and sometimes junior) staff and management.

4.2 Counterbalance “too much good heart”

The mission of CARD’s Mutual Benefit Association in the Philippines is to promote *“the welfare of marginalized women, to extend financial assistance to its members in the form of death benefits, medical subsidy and pension and loan redemption packages, and to actively involve the members in the direct management of the association including the formulation and implementation of policies and procedures geared towards sustainability and improved services”*.

Today CARD MBA offers life and disability insurance, and a pension savings plan (see Chapter 2.2) to 600,000 low-income people. It is a success story – the story of an MBA that was created by a microfinance institution (MFI), but not before the MFI nearly went bankrupt by offering insurance without the needed professional and technical expertise. As one of its leaders explains, “It is fair to say that CARD MBA...arose from a severe miscalculation resulting from too much good heart.”

What happened?

In 1994, several years before it created the bank or the insurance company, the CARD NGO began offering basic life insurance packages to its members. As these services were popular, CARD offered additional and more complex insurance products. In 1996, it decided to introduce a retirement annuity that proved to be extremely popular with members. However, CARD had not evaluated its impact on the institution. An assessment later showed that a member would have to pay premiums for two years just to cover one month of benefit. The institution was at risk of losing its entire capital.

CARD learnt that an insurance business must be run by professionals and should not be tied to the capital of a microfinance institution.

Management extricated CARD from the liability and transferred the assets of the fund to members, who then started a separate company with a separate board.

It appears that, when CARD NGO entered the insurance business, it was being administratively managed, but not governed.

From the management perspective, combining the readily accepted insurance services and a pension plan made sense. However, not much thought was given to the new products' impact on the direction and future of the organization – until the chickens came home to roost.

To its credit, CARD learnt its lesson well. The case study says: “When the board of an insurance company comprises only members or policyholders who have virtually no experience in corporate governance, it is necessary to have an advisory group that is experienced and has the authority to guide the board. Such an advisory committee has been critical to the successful supervision of CARD MBA.”

4.3 Steer an organization with a strategic bent of mind

It is the vision thing. If vision and strategy permeate board meetings – more so than political squabbles and operational details – one can count on an organization's survival and success.

TUW SKOK, an insurer of credit unions in Poland for eight years and of their members and other individuals for the past five years, owes its assured presence in the market to the foresight of the credit union movement's leaders, who charted its entry into insurance services in the early 1990s.

In Poland, other than the government's social protection initiatives for healthcare and retirement, there are no specific efforts to extend insurance to the low-income market. As in most other countries, there is, however, a market niche below what is of interest to mainstream insurers, which is what TUW SKOK is targeting. How it was set up and has been steered holds lessons for those contemplating microinsurance elsewhere – in particular, two strategic decisions that made it virtually foolproof against failure.

The idea of getting into insurance came to the board of the credit unions' apex body not long after the credit unions were re-established in the country and began collecting savings in the early 1990s. A life insurance company was set up with technical assistance and 90 per cent ownership from CUNA Mutual, a United States-based credit union insurance group. It offered three basic products: loan protection, life savings and funeral insurance.

Soon, a brokerage company was added to provide credit unions and their members with covers not available from the joint venture itself. The brokerage is regarded in the case study as one of the most significant steps in the evolution of insurance services for the credit union movement. From the vantage point of governance, however, the strategic decision of stature really came after the joint venture fell apart in 1997.

When CUNA Mutual bought out the local 10 per cent ownership and sold the company to a foreign investor interested in entering the Polish market, the credit union apex's board could have gone ahead with business as usual by replacing the joint venture with a wholly owned operation of the same nature – a life insurer targeting individual members of credit unions. Instead, it opted for a strategic re-evaluation. Based on this analysis, the apex body decided that the greatest priority and most immediate market potential lay in insuring the credit unions themselves rather than their individual members.

So, instead of remaining in life insurance, it chose to have a general (property and casualty) insurance company.

Then came the second key strategic decision: should a new company be launched, which requires business plans and licence approval procedures, or should an existing insurance company be purchased and then restructured to meet the needs of credit unions? The board again made what turned out to be the right choice: to go for an acquisition. Soon the right opportunity came in the form of TUW Praca, a failing mutual insurer under a two-week ultimatum from the regulator to find new capital or be liquidated. The apex convinced the regulator to let it inject new capital into the failing company and reorient it to the needs of credit unions, and TUW Praca became TUW SKOK (*see Box 59*).

Box 59

Read the writing on the wall

TUW Praca's reincarnation as TUW SKOK is not its only legacy – for its terminal illness was caused by a virus infecting many boards of directors – one that should serve as a warning as well as a lesson to microinsurers.

In the early 1990s, as unemployment in Poland began to rise, a group of trade unions launched an initiative intended to offer some protection to workers in state-owned enterprises targeted for restructuring. The idea was to create a mutual insurance company owned by trade unions and their members, which would offer unemployment insurance to workers.

Efforts to raise capital for the insurance company from trade unions did not come close to achieving their intended targets, which should have been a warning sign. Instead, the initiative's backers turned their attention to the Ministry of Labour. The timing of their request was fortuitous because the Ministry had some additional resources and needed to be seen to be doing something about the growing unemployment problem. With US\$500,000 from the Ministry's Job Fund, amounting to 90 per cent of the share capital, the trade unions were able to get a licence to launch TUW Praca. Unfortunately, the effort was essentially stillborn. After a couple of years, the insurer had only 100 policyholders, operating costs had eaten away most of its capital, and regulators were threatening to close its doors.

In hindsight, it appears that TUW Praca's sponsors had not done their homework. Market research would have shown that workers considered unemployment as government's responsibility rather than the responsibility of individual workers. Consequently, trade union members were not interested in buying their own unemployment insurance because they believed that the government should provide that type of social protection.

Source: Adapted from Churchill and Pepler, 2004.

4.4

Clients' interest is the key to results

The role of the board of directors (or the supervisory board as it is known in some European countries) is to oversee the insurer's operations and management. Its central purpose is to act on behalf of the shareholders/sponsors of the company and to direct the organization's activities to attain its corporate objectives. To ensure focus, and checks and balances, the board delegates key tasks, such as audit, investment and executive matters, to its dedicated committees. In the case of mutuals more so than other corporate forms, a key responsibility of the board is to make sure that management's use of funds and other operating decisions are not in conflict with the interests of stakeholders.

The responsibility for managing and looking after the day-to-day affairs and implementing policies rests with the executive management (or the board of executive directors). Serious problems and debilitating conflicts arise when the line between supportive and overseeing responsibilities and managing responsibilities is blurred. A microinsurer whose board of directors has done a notable job of keeping these lines clear is Tata-AIG in India.

India requires what some other countries only encourage: that each insurer have a percentage of its business in the low-income market, locally known as the rural and social sectors (*see Chapter 5.2*). To fulfil these regulatory obligations, Tata-AIG realized that microinsurance is not just normal insurance with lower premiums and benefits, but that the microinsurance customer base has its own distinct profile that requires creative approaches and new distribution mechanisms. It therefore established a specialized microinsurance department, called the rural and social team, and gave it autonomy as well as the needed support and resources to innovate. The important space the team occupies in the corporate structure is reflected in the organizational chart (*see Figure 20*).

As described in Chapter 4.5, one of the team's innovations is a new distribution channel using people like the customers themselves to advise and serve them. A number of these "micro-agents" form a community rural

insurance group (CRIG), which operates as an insurance agency. The micro-agents are essentially handpicked low-income women from the communities they are assigned to serve. Initial results seem promising.

Having a microinsurance champion at board level made the difference.

4.5 Government in governance: Know when to loosen strings

Karnataka, a state in southern India, is known for its software industry and biotechnology, but 75 per cent of its roughly 60 million people earn their income from farming and could be classed as poor. Since 2003, it has also attracted international attention as the home of an unusual and successful micro health insurance scheme that appears to be a model of collaboration among the cooperative sector, government and the private corporate sector.

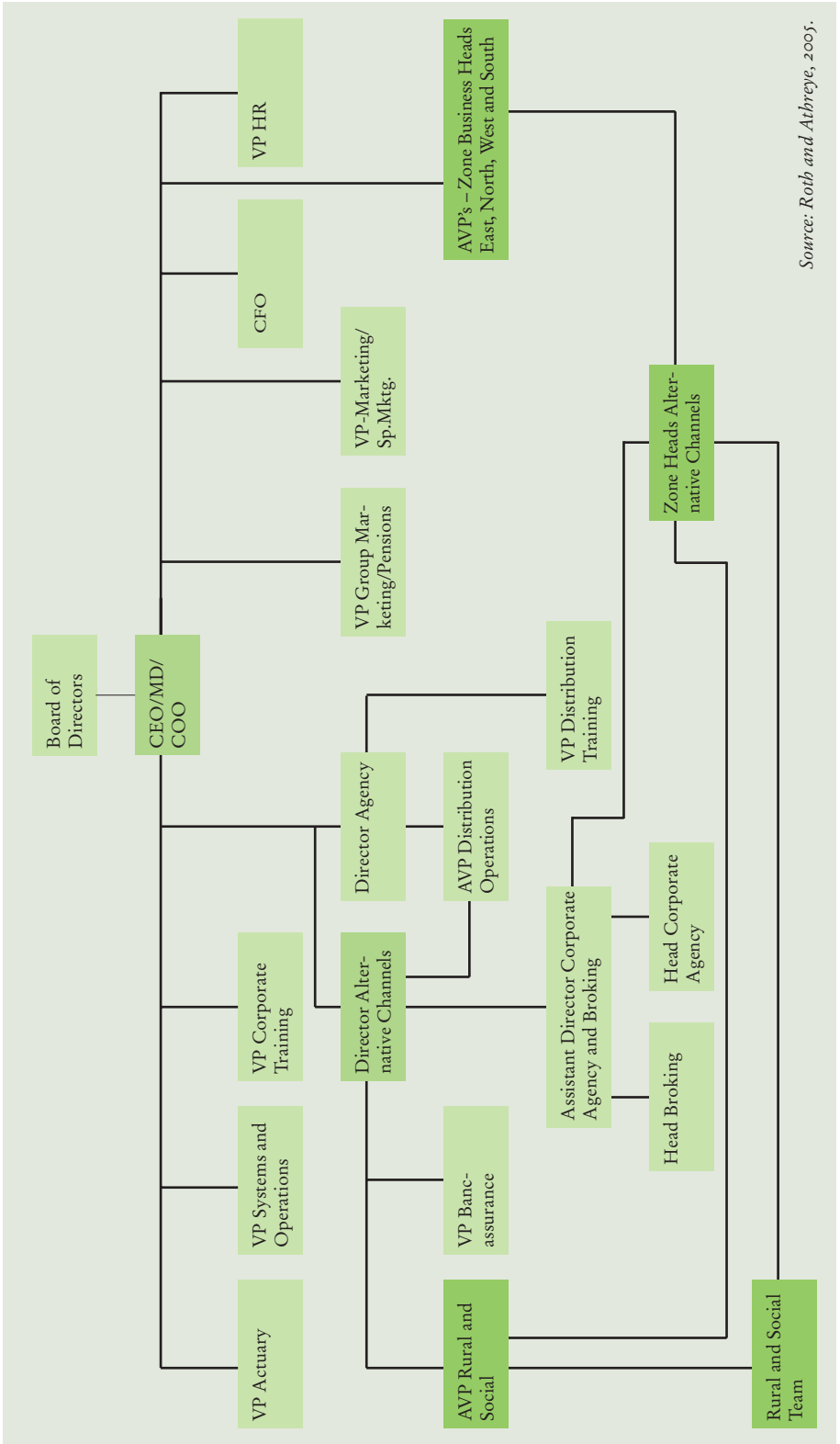
The Yeshasvini Cooperative Farmers Health Care Trust was designed to enrol a large number of people for very low premiums, providing coverage for more than 1,600 operations provided by a network of mainly private hospitals throughout the state.

The state's cooperative movement, dating back to the early 1900s, has some 31,000 societies in sectors ranging from silk production and textiles to animal husbandry, horticulture and agricultural credit. It is estimated that 78 per cent of the state's adult population is connected to a cooperative in some way. Given its tremendous scope of outreach, especially to the rural poor, the cooperative movement was the natural choice for mobilizing the health scheme's potential subscriber base.

The cooperative sector in Karnataka, and other states in India, is publicly sponsored, with the government providing capital, subsidies, loans and technical assistance to cooperative societies. Yeshasvini's collaboration with the state-sponsored cooperative movement has been a mixed blessing, although overall it has been quite advantageous.

Yeshasvini Trust is governed by a 12-member board chaired by the Principal Secretary of the government's Department of Cooperatives. Five other board members are also employees of the Department. Another five represent the network hospitals and are well-known health professionals. The 12th member is the director of the government's Health Department. Representatives of the third-party administrator and the cooperative sector at the federation level may attend meetings, but are not board members. Governing the whole scheme, the board of trustees is responsible for its further development, monitoring performance, listing new hospitals, reimbursing claims and final decisions on claims.

Figure 20 Organizational chart of Tata-AIG



Source: Roth and Athreya, 2005.

The heavy involvement of the Department of Cooperatives on Yeshasvini's board has made it possible for a significant amount of grant funding to find its way to the microinsurer. The government of Karnataka supplemented the Rs. 60 (US\$1.36) premium paid by policyholders in the first year with an additional Rs. 30 (US\$0.68) per person. Although the per capita subsidy was stopped in the second year, the government did provide additional funding. Altogether, the government provided Rs. 45,000,000 (US\$1,022,727) in the first year and Rs. 35,000,000 (US\$795,454) in the second year.

The other main advantage that the Department of Cooperatives brought to the table was the ability to encourage cooperatives to enrol their members. In the first year alone, 1.6 million low-income persons subscribed to the scheme, in part because the Department of Cooperatives issued membership targets to its district offices, which issued a target to each cooperative society, which in turn used its own method of signing up members. Some discussed the scheme with members and encouraged them to join; some signed up all in the society, using their dues; others automatically enrolled everybody with outstanding society loans.

The combination of subsidized premiums and marketing pressure from the government resulted in a membership increase to 2.2 million in the second year. In Year 3, however, when the premiums had to be doubled to replace the subsidy, membership dropped to 1.45 million, which means that 750,000 people were not sufficiently satisfied with the product or price to re-enrol! Given this error of judgement, the case study wonders whether the composition of the board needs to be reconsidered:

Although the Department of Cooperatives facilitates the contact with the cooperative sector, it has to be borne in mind that the cooperative societies have the main burden. It might therefore be advisable to replace trustees from the government by elected representatives of the cooperatives to better reflect their important contribution. As India is currently de-linking the cooperative sector from the government structure, it might be adequate to reflect this in the board of trustees as well (Radermacher et al., 2005b).

The cooperative movement, internationally, has long taken umbrage at government intervention, and the use and misuse of cooperatives in developing countries as a tool for development. In India, where the central government is responding to cooperative societies' calls for democratic reform in their regulation, supervision and functioning, the movement will undoubtedly strengthen as state intervention decreases. India is not a typical case of arbitrary government interference in activities of cooperatives subject to diktats from politicians and civil servants.

In Yeshasvini Trust's success story, the government deserves significant credit. Government involvement in getting Yeshasvini Trust up and running may have compromised the cooperative societies' autonomy, but has not undermined it. The cooperatives appear to have paid a small price for gaining a necessary and well-provided service for members.

There is also comfort for the case from the thoughts of the cooperative movement's ideologue and futurist, Dr Alex Laidlaw. In a "classic" presentation, he said:

Cooperatives tend to take their ideological colour from the economic environment in which they exist. In countries dominated by capitalist ideology, they tend to be judged, and to judge themselves, by the norms of profit-making business. In countries dominated by communist ideology, they are assigned a certain place and role in the economy by State planners and serve as instruments of government policy. In developing countries, they often seem to have the worst of two worlds: they must be competitive with entrenched private business, including multinational corporations, and at the same time follow the dictates of close government control (Laidlaw, 1974).

He added that no business in a national economic system is completely independent and self-sufficient but operates in conditions of dependence and interdependence. Both capitalist business and cooperatives depend to some extent on the state and services provided by the state. Similarly the state and public enterprise depend greatly on private enterprise and cooperatives.

Yeshasvini Trust seems set to go down in history as an example of this dependence and interdependence.

5

Conclusions

Corporate governance ensures the integrity of corporations, financial institutions and markets, building public and investor confidence. To alleviate poverty through microfinance and microinsurance, good governance is essential.

Good governance starts with knowing what it is to manage and what it is to govern. To govern a microinsurer effectively, one must devote time to understand insurance for the poor and take the director's responsibilities and obligations seriously. Some things are better left to management to decide and follow through.

The board of directors is ultimately accountable for the company's success. And success means producing results for sponsors, shareholders and customers so that the insurer is not left short of the capital and surplus required to maintain its financial strength.

The chair and the chief executive should jointly ensure that officials nominated to the board have expertise and skills that make for a proper mix, including a well-balanced composition in representation of various stakeholders. In microinsurance, some key questions should be considered, such as:

- Is there a microinsurance champion to advocate the special needs of the low-income market?
- What is the proper balance between the social/development and commercial/financial orientations?
- What strategic direction makes the most sense to achieve both social and commercial objectives?

3.9

Loss control

Zahid Qureshi and Gerry Noble¹

The authors would like to thank Thomas Loster (Munich Re Foundation) for his valuable comments on this chapter.

In insurance literature, loss prevention, loss minimization and loss control are used almost interchangeably. Reflect on each of these terms a moment and, at the risk of mathematical oversimplification, they boil down to a simple equation:

$$\text{Loss control} = \text{loss prevention} + \text{loss minimization}$$

Loss prevention is initiatives to avoid the occurrence of risks, especially insured events, whereas loss minimization strives to reduce the impact of risks when they do occur. Together, these two activities amount to loss control.

Although not all microinsurers pay attention to loss control, it is a key element of success. Carefully conceived investment in loss prevention can easily pay for itself through reduced claims. Indeed, incentives in insurance are structured in such a way as to encourage private-sector risk carriers to undertake development initiatives – such as promoting safe drinking-water and appropriate sanitation – not to fulfil a social responsibility, but because it makes financial sense.

The purpose of this chapter is to encourage more microinsurance providers, both risk takers and delivery channels, to approach loss control in a systematic and targeted manner. The focus is more on loss prevention than minimization since the former is likely to have a greater impact on reducing the claims costs of microinsurers.

I **A retrospective look at loss prevention**

A snapshot of a typical multi-line insurer three or four decades ago would have shown the loss prevention function tucked away in the commercial or business insurance department. Loss prevention specialists, typically engineers, were a key part of the process of insuring business premises and prop-

¹ The references to Microcare come from the authors' personal experiences.

erties, including office buildings and factories. This is true to this day. Loss prevention specialists work closely with underwriters in shaping premium levels.

The job of the underwriter is to analyse, assess and price the risk exposure for a specified coverage. The loss prevention specialist evaluates the risk management practices and procedures the business has in place, advises the client on any improvements needed, and shares the information with the underwriter for use in understanding and pricing the account. Underwriting research and analysis are done internally; loss prevention, handled in the field, has been underwriting's "eyes and ears".

Over the years, insurers have pursued loss prevention for personal lines too – but most have not called it that. The responsibility is usually built into the marketing and corporate communications function. Off and on, safe driving is promoted to help reduce motor claims, smoke alarms and security measures are recommended to home insurance policyholders, and the benefits of not smoking and a healthy diet and lifestyle pointed out to those who have their lives insured.

The safer the policyholders' driving, the more fire-proof and theft-proof their homes; and the healthier their lifestyles, the fewer claims the insurer will have to pay out and the better able it will be to keep the cost of insurance down. Who could argue with that! It is loss prevention, pure and simple – and no less important than ensuring that a factory is up to code or an office building is maintained properly, in helping keep premiums down.

"All this is good to know," a microinsurance practitioner is likely to say, "but how is it relevant to what we do?"

2 Converging interests

Microinsurance largely involves a variety of products in the life and health insurance lines. Indeed, long life and good health are not a matter simply of staying away from harmful substances, but of warding off hazards hidden in the air, water and food, and maintaining a healthy lifestyle. While many diseases are a global phenomenon, prevention remains largely a priority that local communities are often better placed to pursue. In this fashion, microinsurers – small as well as not so small – can be significant "corporate" players in the communities they serve, and can lead a sustained effort to promote hygiene and other "better health" conditions among customers.

Poverty need not necessarily be characterized by a lack of good health. Loss prevention and good health promotion could become key elements of customer education, which is a prime objective in a microinsurer's marketing strategy. Besides promoting healthy lifestyles to prevent non-communicable

diseases, microinsurance providers could take a cue from the fight against HIV/AIDS and try to increase customer awareness of how pandemics take root, how they could be prevented and how they could be nipped in the bud.

According to a consultant who has worked with a number of microinsurance schemes:

Besides poor hygiene and a poor diet, the greatest health risk for the poor is not seeking appropriate care. A microinsurer's support of public health measures can go a long way in reducing this risk for the poor. For example, SEWA Health in India has worked to improve the training of midwives. This has resulted in lower maternal and infant mortality rates, which in turn have reduced claims costs in the insurance programme. For health insurance, primary care together with health promotion strategies can reduce claims costs and improve the health and productivity of the clients. I have not seen any micro health programme succeed without a health promotion element.

A desirable side effect of such preventative programmes is that it could help grassroots organizations cement working relationships with established insurers that may already be inclined to extend their CSR outreach beyond their existing clientele. Furthermore, microinsurers need to recognize that they are not the only ones with an interest in loss prevention. In an overall win-win approach, partnerships with specialized NGOs working on health issues or with government vaccination programmes can go a long way toward achieving mutual objectives (see Box 60).

Box 60

Taking the societal perspective

Neglecting prevention invariably results in illness and injury to some, but the financial burden is borne one way or another by virtually everyone. Medical expenses affect the income not just of victims and families, but also of their employers and insurers. Care and recovery involve costs to community and public institutions, which governments pass on to taxpayers.

Promoting and practising prevention should also call for a societal perspective and collective action. Microinsurers can be an integral part of partnerships including various organizations and government agencies already engaged in campaigns such as HIV/AIDS awareness, using mosquito nets to prevent malaria and digging wells for safe and clean water. Often a good starting point is a community immunization programme. Case studies provide a few examples:

- **Seguro Basico de Salud (SBS)**, Bolivia, and **Seguro Integral de Salud (SI)**, Paraguay, actively promote the national immunization programmes, including vaccinations specified in the benefits package.
- Several community-based schemes in West Africa have introduced a mandatory vaccination programme for infants. Those not vaccinated are not covered if they get diseases the vaccination programme was designed to prevent.
- **UMSGF** in Guinea plans formal “partnerships with programmes offering efficient prevention measures for diseases covered, particularly malaria and HIV/AIDS”.

Care for the environment, which is capturing increasing attention in insurance and reinsurance circles, is closely related to loss prevention in life and health insurance. Poor environmental conditions not only adversely affect people’s health, but they can also trigger climate change and some catastrophic losses such as droughts. An issue for future consideration is how “going green” might reduce losses and, in particular, how taking greater care of the environment would in the long run help arrest climate change.

3 Pinpointing prevention

While non-life insurers, through their loss prevention specialists, have over the years contributed greatly to safety systems and standards for insured properties and transportation of goods, as well as home and road safety, the same could not be said of life and health insurers (save for readily jumping on the non-smoking bandwagon). Historically, they have not demonstrated as keen an interest in preventing losses.

All accidents and losses seem to have an underpinning cause and effect. Even so-called natural calamities, such as droughts, floods, tornadoes and hurricanes, are now believed to have a root cause: climate change. So, preventing a loss should not be hard once its cause is known.

Loss prevention specialists have built their discipline in non-life insurance by zeroing in on causes of industrial accidents and finding remedies, and so can life and health insurers. Table 31 illustrates the point by analysing an industrial fire, an injury, a communicable disease and a non-communicable disease. The loss prevention column for each specifies remedial action. All call for improved training and increased awareness. Therein lies the crux of loss prevention in microinsurance: counselling and educating customers in ways of taking good care of themselves and their families and possessions.

Table 31

Non-life and life insurance loss prevention

<i>Loss-making condition</i>	<i>Host/Risk</i>	<i>Agent/Flaw in the system</i>	<i>Vehicle of interaction</i>	<i>Interaction/Operation of hazard</i>	<i>Scope of loss prevention/Control activity</i>
Fire	Textile factory	Carelessness of worker	Lighted cigarette end thrown in the wrong place	Fire from the cigarette spreads to cotton fluff	Worker training, installation of smoke detectors, automatic sprinklers, fire alarm, CO ₂ flooding systems
Skull fracture	Human	Managing mechanical energy	Speeding, skidding of motorcycle	Crash	Increasing awareness of safe driving, traffic rules, enforcing road discipline, use of helmet
Malaria	Human	Vulnerable to infection	Mosquito	Bite	Creating awareness of breeding places of mosquitoes, clearing cesspools of stagnant water, fumigation, mosquito nets and other repellents
Lung cancer	Human	Body cannot tolerate intake of smoke	Habitual and excessive smoking	Increasing damage to lungs	Creating awareness of the harmful effects of smoking, and ways of dealing with addiction

Source: Adapted from Thomas, 2004.

On the surface, such an undertaking may appear superfluous to microinsurers struggling to build and maintain a book of business. However, if they take a holistic view of the business – not just income, but also the institution’s viability – loss prevention emerges as life-sustaining. The obvious, short-term benefit is that it reduces the frequency and severity of claims, and helps control the insurer’s expenses. But the real advantage is that it protects the insurer’s income over the long term: ensure that customers remain healthy and productive, and the organization will be sure of their continued patronage.

JA Zenchu, the Central Union of Agricultural Cooperatives of Japan, has long recognized the value of such a seemingly extracurricular service that, in effect, adds value for the business as well as the customer. Its chain of multi-purpose cooperatives in rural communities provide a popular “better-living guidance” service in addition to the core business lines: marketing of farm products, supplies of production inputs, credit and mutual insurance, and farming advice. The better-living guidance to members and their families

includes health management, lifestyle counselling and advice, household budgeting, recreational activities and joint purchases of high-quality daily necessities.

Health promotion and prevention activities have a long way to go in the developing world. Indeed, the scope of the work that could be carried out by life and health insurers in this domain is quite different in developed and developing world markets. Microinsurers are perhaps at an advantage in this respect, since they could encourage their clients to do many simple things that do not reduce their capacity to meet basic needs and may over time even enhance their ability to cope (*see Box 61*).

Box 61

Promoting well-being

A number of microinsurance schemes, or related organizations, actively promote healthy living to reduce illness among policyholders, and therefore reduce claims. For example:

- **Karuna Trust** (India) runs herbal gardens in six villages used to train clients to produce herbal medicines.
- **Bienestar Magisterial** (El Salvador) has special programmes for cancer detection, family planning and prenatal care.
- **Shepherd** (India) runs medical camps for check-ups. It also runs cattle-care camps with free immunization and de-worming. The camps serve a marketing and recruitment purpose too.
- **Grameen Bank** (Bangladesh) has its “16 decisions” that members recite at meetings, including pledges “to look after our health”, “grow and eat more vegetables”, and “keep our homes and environment clean”.

It makes sense for conventional insurers to remind customers how stress affects the heart and the nervous and digestive systems, to ask them to recognize stress symptoms that can ring the alarm bells before a burnout, and to encourage them to join walking clubs and fitness centres. For microinsurers, however, the focus is likely to be on different issues. For those in Prahalad’s BOP market, loss-prevention initiatives may concentrate on hygiene and cleanliness – how simple things like keeping the “kitchen” clean and washing hands and vegetables before eating can prevent diseases.

4 Practising prevention

How exactly insurers should go about engaging customers in loss prevention also needs to be put in the proper perspective. Those serving the top of the pyramid may make their staff and meeting rooms available after hours for

counselling sessions, or set up wellness centres to dispense advice, assistance and referrals. However, these measures would hardly be appropriate for the microinsurance market.

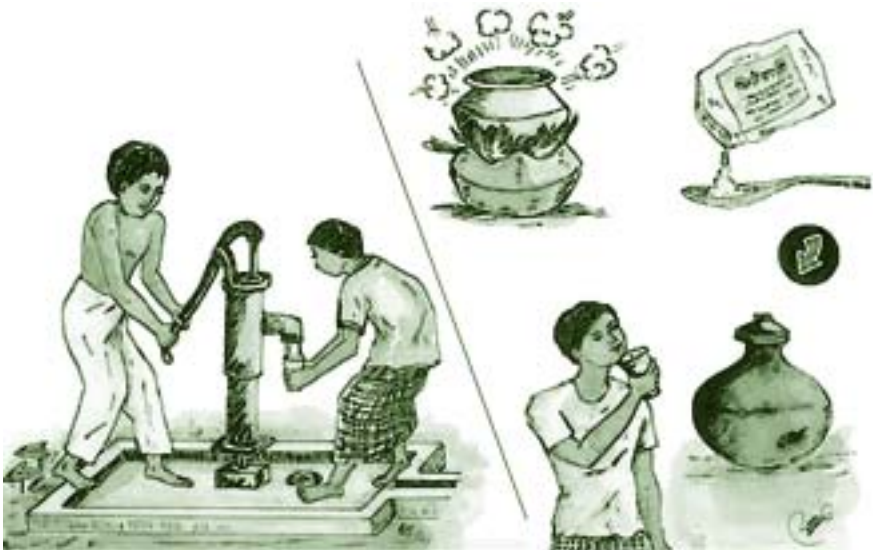
Loss prevention initiatives for the low-income market are likely to look quite different. The approaches might include the following:

- **Outreach by sister organizations:** VimoSEWA of India, and Grameen Kalyan and BRAC MHIB (both Bangladesh) all have sister organizations involved in healthcare initiatives, such as barefoot nurses and midwives, which are natural partners in prevention campaigns (*see Box 3*).
- **Use of non-formal adult education methods:** In some countries, the target market for microinsurance may be illiterate or have limited education. To communicate loss prevention to this audience, innovative techniques are required, such as illustrated posters (*see Figure 21*) and street theatre. Learning conversations, a technique promoted by Freedom from Hunger, are based on real stories that illustrate the daily problems of the target market. Discussions about the story serve several purposes: to help participants to become aware of a specific problem, to collectively solve a specific problem faced by members and to reinforce cohesion among group members and enable them to take collective action.

Figure 21

Illustrating Grameen's 16 Decisions

Decision 10: We shall drink water from tubewells. If it is not available, we shall boil water or use alum.



- **Hammer home the core messages:** Effective campaigns are continuous, relying on a variety of communication channels to ensure that the main messages are absorbed and, hopefully, change behaviour. Indeed, each time a Grameen Bank centre meets, the members recite the 16 Decisions.
- **Target the children:** One of the most effective ways of changing the behaviour of adults is by educating children, who can then nag and cajole their parents into less risky practices.

*Box 4***Prevention through sister organizations: VimoSEWA**

Mainaben, a fish seller, has been a SEWA member for 27 years, borrowing for her business and for her house. Six years ago there was a plague epidemic in some parts of India. SEWA arranged a special community clean-up awareness programme to protect communities against the plague. Mainaben was made an organizer to promote community cleanliness in Chamanpura. She spoke to the local people about keeping their houses clean, and she petitioned the Municipal Corporation and the State to clean up rubbish. The Corporation was so annoyed with her constant petitions and her threats to demonstrate against them that on one occasion they even sent the police to scare her. However, Mainaben prevailed, new rubbish bins were provided, and regular rubbish clean-ups were organized.

Mainaben's hard work caught SEWA's attention, and she was trained and employed as a health worker. She covers a community of 200 households. She sits at SEWA's clinic from 10:30 in the morning to 1:00 in the afternoon. From 1:30 to 4:00, she makes the rounds of her neighbourhood. She visits each house at least once a week. She provides information on disease prevention; she provides basic medicine to SEWA members (at a cost of two rupees, or four and half a US cents, for children and four rupees for adults), makes referrals to doctors and hospitals and follows up on patients.

Mainaben encourages everyone to take out health insurance. She tries to convince women to enrol in the fixed deposit programme. If they cannot, she tries to convince them to pay annual premiums. A few women save with her to accumulate the money for the fixed deposit. Women will contact Mainaben for all their insurance claims. Women in the community say that they appreciate Mainaben and her healthcare advice. She has assisted the people in her community to obtain better and, more importantly, more affordable healthcare.

Source: Adapted from McCord et al., 2001.

- **Rely on peer pressure:** One of the more effective ways of creating sustainable behaviour changes is by using the peer pressure from groups to continue to encourage (or enforce) the new conduct.
- **Provide tangible benefits:** Sometimes behaviour changes involve artefacts. For example, SEWA has on occasion provided market vendors with umbrellas to reduce the chances of heat stroke. Microcare subsidizes insecticide-treated bed nets (*see Box 64 in Section 6*). These tangible benefits help make intangible insurance more acceptable to the poor.

5

Minimization: A stitch in time

Prevention, obviously, precedes a loss. Steps to minimize the impact of the loss – that is, reduce it to the smallest possible degree – are taken after it occurs. However, prevention usually involves anticipating or foreseeing a loss, and that process may entail at least a modicum of minimization, actually doing something about the foreseen loss – which may be one reason why the two terms are often synonymous in talk of risk management. Semantics aside, the point is that the more the insurers can do to prepare a policyholder to respond quickly and efficiently to a setback, the better off both the individual and organization will be.

Minimization is particularly relevant for health insurance. Thomas (2004) specifies how the ill effects of an illness or injury might be minimized through better management of time and process from the moment and point of occurrence to admission to the hospital. Most of the steps he described (such as an SOS to ambulance and prompt action by paramedics) were meant for deep-pocketed insurers with a wealthier clientele, but they would give those involved in microinsurance an indication of how one might approach minimization. Some of these measures could be adapted and scaled down to fit the budget, resources and community contacts accessible to microinsurers.

The following are key aspects of loss minimization:

- **Recognizing body conditions is critical.** The insured should be able to recognize ailments and the body's warning signals. They should know the dos and don'ts in the event of a health condition, and take steps to prevent the condition from worsening.
- **Correct information is needed for correct action.** Policyholders armed with the right information are better prepared. They should be given brochures containing addresses and telephone numbers of doctors, trauma care centres, and specialized hospitals, and details of procedural formalities on admission.

- **Help when needed.** In an emergency, unprepared policyholders can only wring their hands. Even normally efficient people may become panic-stricken and find themselves unable to make the right decisions. A 24-hour telephone help-line service would:
 - give policyholders step-by-step guidance,
 - locate a convenient ambulance service,
 - direct them to appropriate medical attention, and
 - alert the hospital about the patient's arrival.
- **Creating own infrastructure.** A group of insurers together can create a support-services infrastructure for education, counselling, tie-ups with hospitals and related medical units and mobile trauma care.

While one cannot prevent a natural disaster from happening, it is possible to minimize its effect on the insured population through disaster preparedness. Japanese insurers have taken the lead in developing techniques to raise awareness among the general population about disasters and disaster preparedness (*see Box 63*).

Box 63

Coping with disaster: The Japanese experience

In Japan, the 1995 Kobe earthquake gave rise to civic-mindedness, with quick action by families at the heart of the collective response to the crisis. Perhaps this should not be so remarkable since a distinctive feature of Japanese society is the strength of cooperatives, including cooperative insurers. Zenrosai, the National Federation of Workers and Consumers Insurance Cooperatives, helped victims with money, counselling, and psychological services; the Japanese Consumers' Cooperative Union (JCCU) led trade and business groups in lobbying for a national security system for disaster relief.

Meanwhile, disaster mitigation activities remained focused on the family. The General Insurance Association of Japan designed a programme targeted at elementary school children to raise their awareness of disasters and to increase their ability to cope with them. The interactive pedagogical tool is not only informative, but is also fun for the children. They are first briefed on the basic idea behind the activity and then are divided into small groups and taken around their town. The children go to facilities that play an important role when disaster occurs, such as police stations and hospitals, and talk to the people who work there. Upon returning to the classroom, the children draw a map of their town's disaster-related facilities, and decorate the map with photographs and leaflets gathered during their trip.

The Kobe earthquake also led to an uptake in natural catastrophe coverage. Zenrosai and another cooperative insurer Zenkyoren (National Mutual Insurance Federation of Agricultural Cooperatives), one of the world's largest insurers by assets, now have more than 15 million policies with add-on natural catastrophe insurance. The policies offered by these cooperatives are “multiple-step policies”, where insurance payouts are tiered or stepped up as a function of the damage ratio.

Source: Adapted from the General Insurance Association of Japan and Zenrosai and Zenkyoren websites.

6 Evaluating the return on investment in prevention

How should a microinsurer go about determining what prevention measure is needed, whether it would be worthwhile, and how its value might compare with other measures that could possibly be taken? In general, this exercise boils down to a four-step process:

1. **Identify claims trends:** The first step is just basic insurance management: monitoring claims to see if there are any patterns or trends in causes of deaths, types of illness or other risks and perils.
2. **Develop prevention strategies:** If there are claims trends, which ones could be controlled by what kind of prevention programme? Are the proposed measures within the insurer's capacity to implement? What is the cost of the measures and what is the expected return in terms of lower claims?
3. **Implement prevention activities:** If particular measures appear to be cost-effective, the human and financial resources required need to be identified and the activities implemented.
4. **Monitoring the results:** To justify investments in prevention, the insurer needs to see the corresponding reductions in claims. Has the programme resulted in any reduction in losses? This is more or less what Microcare did in Uganda, as described in Box 64. In assessing the effectiveness of a prevention measure, the microinsurer might want to consider the intangible marketing or promotion value of the activity, besides the tangible benefit of lower claims costs.

Box 64

Microcare: Using insecticide-treated bed nets to reduce malaria-related claims

Microcare is a unique microinsurance organization, having been transformed from a not-for-profit background to become a fully fledged insurance company in Uganda specializing in health insurance. Microcare focuses on the low-income market, drawing from the formal and informal sectors and span-

ning urban and rural locations. Microcare's objective is to provide "affordable access to quality healthcare".

Malaria is endemic throughout Uganda and the commonest diagnosis for Microcare's health insurance clients, particularly in rural areas. Cumulatively, the claims cost paid by Microcare for malaria is more than that of any other diagnosis. To make matters worse, the cost of treating malaria in Uganda is set to increase as its resistance to chloroquine becomes widespread. Chloroquine has been the cheapest treatment commonly used for malaria, costing less than US\$1 for a full course. Drug resistance has forced the Uganda Ministry of Health to change the recommended first-line treatment protocol to regimens based on Artemether compounds accompanied by one other drug (to discourage rapid emergence of Artemether resistance as well). These Artemether-based combinations cost about US\$7 for a course of treatment.

In Uganda, the prevalent form of malaria is falciparum, the most dangerous type, which can cause cerebral malaria and death, particularly in the non-immune (e.g. children). Falciparum malaria frequently leads to hospitalization if not treated quickly in the early stages. The epidemiology of the disease is complicated further by the continuing emergence of new strains to which local people are not immune. The insect vector for the disease, the female anopheles mosquito, thrives in Uganda, particularly during the rainy season. This factor, combined with the emergence of new strains, leads to severe intermittent seasonal epidemics of this already pandemic disease.

The use of insecticide treated nets (ITNs) is a widespread and well-documented malaria prevention measure. Commonly, these nets are treated with permethrin-based compounds (a derivative of the pyrethrum plant). Bed nets can be treated by incorporating long-acting forms of the insecticide into the mesh during the manufacturing of the fabric which are released slowly over the two-to-three-year lifespan of the net, or by regular immersion of the bed net in a solution of insecticide after washing.

By acting as a physical barrier, the net prevents mosquitoes from making contact with and biting the sleeping person. The net is treated with an insecticide, so when mosquitoes are attracted to the potential human victim, they land on the outside surface of the net. While resting on the net, the mosquitoes absorb a dose of the insecticide adequate to either kill or debilitate them. Since anopheles mosquitoes do not usually bite people during the day, treated bed nets make a substantial contribution to malaria containment. However, people are still vulnerable in the evenings before going to bed and when getting up early in the morning – an unavoidable limitation of the effectiveness of mosquito nets for malaria prevention. In Uganda, a treated double-bed mosquito net costs around US\$6.

Microcare has already started to provide subsidized (half price) insecticide-treated nets to rural clients and has experienced a good uptake. The logic of subsidizing nets, as opposed to making them free, is that people value something more if they have paid for it, and are more likely to use it properly if they value it.

Since clients frequently suffer more than one attack of malaria per year and more than one person will sleep under a double-bed net, the economics make a compelling argument. A US\$3 subsidy to prevent two or more people getting a frequently occurring disease that would, with the new drug regimens, cost US\$7 to treat. The nets should last for several years and have become a popular marketing tool for Microcare.

At this point (six months since the start of the subsidized net programme) assessment of its impact cannot be done accurately because it is necessary to complete a full year of the intervention to allow for seasonal variations in epidemiology. However, the “buy-in” of the client community for preventive measures has already been seen. Prevention helps neutralize the argument “I paid my premium, but I didn’t get sick,” because the insurer can reply: “The reason you didn’t get sick is our prevention programme!”

So Microcare is now turning its attention to preparing programmes targeting other diseases amenable to prevention and education. Sexually transmitted infections (including HIV/AIDS), sanitation-related water-borne diseases and the emerging “Western diseases” such as obesity and the resultant adult onset of (Type II) diabetes are all under active training material development by the Microcare Preventive Health Department.

A basic programme like Microcare’s, and those highlighted in Boxes 60 and 61, show that a range of simple and effective loss-control programmes can be implemented by microinsurers under various local conditions, possibly in partnership with other organizations and government agencies.

In mainstream insurance, putting a value on a loss-control measure in the physical damage line is relatively simple. If a non-life insurer expects a million motor claims in a certain year for windscreen replacement, and if a preferred body shop quotes a three-dollar discount on each, the insurer would save US\$3 million minus the cost of a communication programme to ensure that all branch offices require claimants to go to the chosen body shop.

However, how can an insurer determine the value of a prevention measure designed to lower the cost of claims for personal sickness or injury? The Microcare programme in Uganda, using comparative figures for claims experience before and after the programme’s implementation, points the way for microinsurers. However, when it comes to evaluating the cost-effectiveness

of a number of programmes more precisely for the purpose of choosing the most suitable one, the calculation becomes complicated, and experts such as statisticians and actuaries need to be involved.

7 Conclusions

The main points and recommendations from this chapter are:

- Loss control has two key elements: loss prevention and loss minimization.
- Loss prevention has evolved into a professional discipline in non-life insurance, and has resulted in improved risks and safety standards as well as savings in claims costs for insurers and in premiums for the insureds.
- Life and health insurers can also achieve these benefits as the world faces new threats of viral pandemics and environmental hazards.
- Microinsurers can adapt the industry's loss-prevention and loss-minimization measures and benefit from helping policyholders become less prone to diseases and better prepared to deal effectively with setbacks in health. These measures help reduce costs for the insureds (lower premiums) as well as the insurer (fewer claims).
- A wide range of simple and effective loss control programmes can be implemented by microinsurers under various local conditions, possibly in partnership with other organizations and government agencies.
- To calculate the value and cost-effectiveness of prevention measures, microinsurers could diligently analyse comparative figures for claims experience before and after a prevention programme's implementation.
- Loss prevention can demonstrate that insurance is not only about collecting money and paying for a loss. It is a comprehensive package which both protects and cares for people.

3.10 Performance indicators and benchmarking

Denis Garand and John Wipf¹

The authors appreciate the editing and suggestions on this chapter provided by Alexia Latortue and Aude de Montesquiou (CGAP), and Ellis Wohlner (consultant to SIDA).

Microinsurance has the potential to provide much-needed protection for the poor. Since microinsurance is relatively new, it presents an opportunity for the insurance industry to learn new and superior skills, such as developing low-cost delivery mechanisms to grow this market effectively. A realistic set of benchmarks in the form of operational standards and performance indicators can be an excellent guide for microinsurance managers aiming at continuous improvement and excellence.

In mature insurance industries, for example, rating agencies and regulators use key insurance ratios to monitor and flag companies that are at risk of failing. This permits timely intervention that may save the insurance company. Similarly, many insurance companies use industry performance benchmarks to compare themselves to their competitors, and this helps them understand areas that require improvement. A relevant set of indicators paired with industry-accepted benchmark values (standards of performance) can be a signpost for management, boards and other stakeholders, helping them to ensure that the company remains solvent and that performance continues to improve.

Developing key performance indicators for microinsurance and periodically publishing the performance of all participating microinsurance schemes relative to an established set of benchmarks should be a priority, as this contributes to the development of a robust, transparent and sizable microinsurance market. Performance standards are operational goals that help a microinsurer achieve viability, while indicators are used to measure the extent to which the established standards are achieved. These indicators, both qualitative and quantitative, should be primarily focused on key financial measures since these provide a rapid assessment of the organization. They should cover the entire range of operations, including marketing and distri

¹ The references to Bungwe (Rwanda), TYM and Dong Trieu (Viet Nam), Confederation Life (Canada) and the pre-need insurance industry in the Philippines are based on the authors' experiences.

bution, investments and risk management. Managers should measure the performance of their operations and compare it to that of similar organizations at least annually. Donors may also want to evaluate the current position of a partner relative to others in the industry.

The main objective of this chapter is to discuss some of the more important indicators that should be included. In addition, the chapter touches on why these selected indicators are useful in evaluating the general health of a microinsurance programme and highlights areas that may require further development. For these to be useful and manageable, there should only be five to twelve initial key indicators. If major concerns are identified, then managers can drill down to more detailed indicators designed to isolate more specific issues.

Since microinsurance implementation varies greatly between countries, cultures and affiliated sectors, the indicators reviewed here are intended to cover most situations and apply to microinsurance as a whole – that is, a scheme consisting of one or more of the following players: a delivery agent of an insurance company, a service provider, a third-party administrator, an insurance company or a stand-alone risk-bearing microinsurance organization.

The basic assumption is that an organization promoting microinsurance has an interest in understanding all aspects of the insurance programme and is aiming for its long-term sustainability. This chapter covers indicators in four key areas: 1) marketing and distribution, 2) financial management and viability, 3) efficiency and client value and 4) investment management.

1 Marketing and distribution

Marketing and distribution effectiveness is one of the most important requirements for the long-term sustainability of a microinsurance scheme. Without successful marketing, the organization is unlikely to reach or retain the critical mass that it needs to survive. Successful marketing in turn largely depends on the client's satisfaction with the services and perceived value of the products. In this category, there are three key ratios: participation, renewal and persistency.

As an indicator of marketing effectiveness, the **participation rate** refers to the proportion of eligible members of a target population participating in the microinsurance programme at a given point in time.

*Participation rate = total number of members/eligible members
of the target population*

The ideal situation is when a very large proportion of a target population voluntarily participates in a microinsurance programme, which generally indicates that the population has accepted the concept of pooling risks and resources. It is also likely that these participants have a good understanding of the benefits package and know how to access the benefits.

In Rwanda, Bungwe health microinsurance scheme, launched in 2001, achieved a 24 per cent participation rate in its first year of operation. This rate has increased each year and in 2005 a remarkable 95 per cent of the community was participating. This scheme was viable in its first year of operation. The success of the programme may be due to clients understanding the solidarity aspect and seeing great value in the scheme since it provides access to the village's health centre and ambulance services, and to the developers of the scheme being well-attuned to the needs of the population.

Conversely, at TUW SKOK in Poland, just 10 per cent of targeted credit union members enrol in the insurer's voluntary services. This low participation rate may indicate that the product lines are not attractive to most members or that members consider the company's products and services offer poor value, or possibly that the marketing skills of the distribution channel are ineffective. In any case, management should take notice of the low value of this indicator and aim to understand why it is unable to attract a greater percentage of their target market.

One way to attain a high participation rate is to make cover compulsory. This is only possible in certain cases, such as for the borrowers of an MFI or when cooperative members vote for mandatory coverage at their general membership meeting, but it is virtually impossible to enforce in a community scheme. CARD in the Philippines requires all its eligible borrowers to join the mutual benefits association (CARD MBA). Similarly, TYM and Dong Trieu in Viet Nam require that their microfinance borrowers participate in the microinsurance scheme.

Mandatory coverage does not mean that the microinsurer can become lax in its marketing efforts. These products and services must be continuously sold and good value maintained, otherwise resistance to the compulsory participation will escalate. CARD appears to be successful at this, with many MBA members stating that the insurance products are their principal reason for joining CARD (*see Box 65*). Furthermore, in 2004, Dong Trieu clients in focus group discussions expressed satisfaction with the microinsurance programme despite its limited benefits, mainly because the clients felt honoured to contribute to a fund that may someday help fellow clients facing difficulties. In both cases, the organizations successfully implemented microinsurance programmes with compulsory participation.

Box 65

Great value placed on insurance

In a 2002 qualitative survey conducted by Freedom from Hunger, 12 out of 27 focus groups interviewed named MBA insurance as *the most valuable aspect of the entire CARD product portfolio*. Such a result runs contrary to experience with similar arrangements in other countries where mandatory insurance is never rated highest on a scale of product value for an institution that offers savings and credit facilities, often because of its intangible nature.

Source: Adapted from McCord and Buczkowski, 2004.

The **renewal rate** is a related indicator but applies specifically to term products (products with a fixed term of coverage such as one year). It is defined as the percentage of clients who had coverage in the previous year and are still eligible for renewal, who are renewing their term coverage. It reflects (among other things) the satisfaction of the client once the term product has been purchased.

$$\text{Renewal rate} = \frac{(\text{number of clients from Year X continuing coverage in Year X + 1})}{(\text{number of clients in Year X})}$$

A more general measure is the **persistence rate**, which refers to the number of clients from a cohort continuing their coverage at a later date divided by the number of clients from the same cohort with coverage in Year X. It is more general than the renewal rate since it applies to both term and continuous coverage.

For schemes with voluntary participation, low renewal and persistence rates are often indicative of client dissatisfaction, possibly due to poor communication, unacceptable product value, unsatisfactory claims payment, and so on.

Operationally, high participation and persistence rates help to reduce administrative expenses. This adds value to the product since a larger proportion of the premium can be returned as benefits, which in turn encourages even wider and longer-term participation (*see Figure 22*). For example, in Guinea, UMSGF's relatively high renewal rate of 81 per cent and a 30 per cent participation rate among the targeted population helps achieve a low expense ratio of just 18 to 20 per cent of gross premium. This low expense ratio enables the scheme to offer more attractive benefits and may be a reason for the high rate of renewals.

Figure 22

The circular logic of customer retention



In contrast, low renewal rates over extended periods will increase costs per unit of insurance since the fixed costs of the programme must be distributed over fewer insurance units, which dampens participation and persistency even more since high expenses result in reduced product value. It is very likely that the ambivalence of Delta Life (Bangladesh) towards its low persistency rate contributes towards its high (although improving) expense ratio and equally likely that the high expense ratio reinforces the low persistency rates due to poor value.

The reader may wonder at this point, “What are acceptable participation and renewal/persistency rates?” There is no straightforward answer to this question since it depends on factors such as the type of microinsurance scheme, the size of the target population, the distribution channel and how long the programme has been set up. An MFI-linked scheme such as CARD’s, for example, cannot be compared fairly to a programme such as Delta Life’s which relies on foot soldiers selling individual policies, without some sort of calibration of the scoring mechanism.

This suggests that the scoring formulas for the proposed set of indicators should consider as parameters the microinsurance scheme’s type, the time that has elapsed since it was established, its product lines, target market, distribution channels and so on. For example, it may well mean that a commu-

nity-based health insurance scheme achieving a 30 per cent participation in Year 5 would score just as well or better than a credit union achieving a 65 per cent penetration rate in Year 4 with its voluntary credit life product being marketed to its narrowly defined target market, i.e. its borrowers.

Perception of good value results not only from a high benefit-to-premium payout ratio, but also from satisfaction with the servicing. It is likely that VimoSEWA's low renewal rates have improved in recent years in part because of better servicing and shorter claims turn-around times (*see Table 32*). On the other hand, detailed client satisfaction surveys would probably confirm that Delta Life's low persistency rate is not at all helped by extensive delays in claims payments, minimal efforts on policy services and high claims rejection rates.

Table 32

Improved service enhances retention at VimoSEWA (India)

<i>Period</i>	<i>Renewal rate (%)</i>	<i>Time to pay health claims (days)</i>
2002	Not available	90
2003	48	70
2004	51	62
2005	59	59

Note: The time in days taken to reimburse health claims is measured from the date of hospitalization. The average time for a member to submit a claim is 40 days.

Unfortunately, in some environments low persistency rates may actually result in higher profits for the company. For example, the commercial pre-need industry in the Philippines (offering mainly education, pension and pre-paid burial plans) profits greatly from the low cash value payouts upon surrender of pre-need policies.² The strategy of some unscrupulous companies is to offer very high commission rates to individual agents in the initial policy years, but then drastically reduce the commissions in the third and subsequent years of a five- or 10-year plan. This results in very aggressive selling, often to reluctant buyers who then cancel their policies or allow them to lapse in droves in the third and fourth policy years when the agents turn their attention elsewhere. The company then profits from the early cancellations since the surrender payout requirement is very low.

² The pre-need industry in Philippines is a special sub-sector of the insurance industry where companies offer savings plans with insurance features to address future needs such as retirement, children's weddings, burial expenses, education and so on. It is currently regulated by the Securities and Exchange Commission, but there is a pending bill to transfer it to the Insurance Commission.

Obviously, these sales practices run counter to the spirit of microinsurance. In some countries, the low-income market has exposure to dishonest insurance schemes and, as a result, real microinsurers have to work extra hard to demonstrate that they are indeed different.

2 Financial management and viability

One of the most important indicators is the microinsurer's net financial result or **net income** since this reflects performance in all activities in the period reviewed (*see Table 33*). It should be computed net of subsidies and grants received. To measure net income, an accurate profit and loss statement on an accrual accounting³ basis has to be produced, which takes account of all costs of administering the scheme, depreciation of equipment, reserve increases, and so on.

Net income (prior to non-permanent subsidies) = Earned premium + investment income – claims incurred – operating expenses – reserve increases.

Producing accurate financial statements is an important management function of a microinsurance scheme. Results should be shown by product line to make it clear where the programme is losing or making money. This requires proper allocation of expenses on an accrual basis and by product line, as well as correct calculation of actuarial reserves since reserve increases must be recognized as an expense. The ability to produce a profit and loss statement, a balance sheet, and a cash flow statement by product line should be a standard requirement for all microinsurance schemes and it should be possible to monitor this ability using qualitative indicators.

Some products such as credit life are usually profitable within the first year if implemented properly, while others such as health insurance may take several years to reach profitability. Obviously a positive net income over several years suggests viability of the microinsurance scheme, at least in the short term, while an organization with significant and consecutive negative net incomes will have difficulty surviving for very long since its capital and surplus will be eroded to a point where it becomes insolvent.

³ **Accrual accounting** is a method that measures the performance and position of a company by recognizing economic events as they occur, regardless of when related payments take place.

Table 33

Selected examples of net income

<i>Organization</i>	<i>Microinsurance start date</i>	<i>Type of product</i>	<i>Net income as a percentage of earned premium</i>
CARD MBA	1994 informally, 1999 formal registration	Credit life, whole life, and savings products	31 (2003)
MUSCCO	1980	Credit life and life savings	40-45 (2003; incomplete information on earned premium)
Spandana	1998	Life and hut insurance	20 (2003-2004)
AssEF	2003	Health	-24 (2004) before subsidies
VimoSEWA	1992	Life, accident, health, and asset protection	-51 (2004) before subsidies

The amount of net income should reflect the desired goals of the scheme. The goals of a start-up scheme are typically to provide good value for the participants and to remain viable in the medium to long term. For more mature programmes however, the goals may be expanded to reflect a desire for a competitive return on the shareholders' or members' surplus and capital, or to transform the scheme into a fully capitalized insurance company.

The net income has a direct effect on the **solvency ratio** defined here as the total liabilities of the microinsurance scheme divided by its admitted assets.⁴ Clearly this needs to be below 1 for the scheme to be technically solvent. For example, MBAs in the Philippines are required by the Insurance Commission to maintain a solvency ratio of 0.80 or lower.

$$\text{Solvency ratio} = \text{total liabilities} / \text{total admitted assets}$$

Another important indicator for this category is the **liquidity ratio**. Even if a microinsurer has a healthy solvency ratio, it could still have problems paying claims and expenses if it does not have adequate cash or cash equivalents in the short term (*see Box 66*). Too much cash, on the other hand, usually means that the scheme is forgoing investment opportunities, which will result in higher premiums or lower benefits for the participants.

⁴ **Admitted assets** are those allowed by the regulator to be included in the solvency ratio calculation; typically, these are higher-quality assets, but may also include such items as the residual value of the company's equipment.

Liquidity ratio = cash and cash equivalent investments / probable payouts within a year.

Box 66

What doomed Confederation Life of Canada?

For developed insurance companies, a classic reason for failure is illiquidity. A large insurance company in Canada, Confederation Life, failed mainly due to the high proportion of its funds invested in illiquid property. By 1990, Confederation Life was one of the largest life insurance companies in Canada. Its over-investment in property led to problems however, when the booming real estate market began to fall, resulting in large losses in value for Confederation Life. Even more importantly, it generated a liquidity crisis. On 12 August 1994, the regulators declared the company insolvent. Many years later, the bankruptcy administrators were able to pay all outstanding obligations of the insurer after they had had sufficient time to sell the company's property assets.

3

Efficiency and client value

As mentioned above, good product value is one of the most important catalysts for the participation rate and for the programme to remain viable. Good value, however, can only be achieved with a low **expense ratio**, which is the proportion of the premium earned in a given period consumed by incurred operating expenses in the same period.

Expense ratio = Incurred operating expenses / earned premium

By definition, microinsurance premiums are small and are usually collected in frequent instalments. The result is a very large number of transactions relative to premium amounts, which makes it difficult to maintain a low expense ratio. Because of this, viability can usually be achieved only if an existing collection system is utilized (see Chapter 3.3). The best example is a microinsurance programme linked to an MFI, where premiums are collected together with the microfinance loan repayments. Another example is Yeshasvini (India), which collaborates with milk-producer cooperatives by collecting directly from the co-ops, which then deduct the premiums from the proceeds that the farmers earn from daily milk deliveries. Voluntary products aimed at the wider community also require some mechanism to reach large numbers of participants efficiently, such as using savings and credit groups.

As a rule of thumb, to be effective in microinsurance the target expense ratio should be below 30 per cent in the early years of the scheme, but with a trend towards 20 per cent or less after the programme has stabilized. CARD MBA achieves an expense ratio well below 20 per cent by riding on the collection system of the associated MFI. This target is much more difficult to achieve for schemes like Delta Life, which offers individual life products with premium collection carried out by field staff going door-to-door.

A good complement for this indicator is the **incurred claims ratio**, defined as total incurred claims divided by earned premium in a given period. Good product value requires that as much of the premium as possible be returned to the members in the form of benefits. **Maintaining a high claims ratio while at the same remaining viable is the crux of the microinsurance challenge.** Clearly this can only be achieved with maximum operational efficiency resulting in a low expense ratio and by maximizing the investment returns on the scheme's reserve funds (*see Table 34*).

Incurred claims ratio = incurred claims / earned premium

Even though CARD MBA has an expense ratio below 20 per cent, its claims ratio for credit life is approximately 16 per cent which is very low. If this low claims ratio is maintained over time, many members may question the value of the insurance programme. The MBA should consider either lowering the credit life rates or providing some additional benefits since both dividend payouts and cross-subsidization of products are not permitted for an MBA.

Delta Life with its high expense ratio of over 40 per cent and a very low claims ratio calls into question the value of providing endowment products to the low-income markets – perhaps individual endowment products may not be the best savings vehicles for the poor (*see Chapter 2.2*).

Another measure in this category is the **time to payout** – how many days it takes for a client to receive a payment after the occurrence of an event. Paying claims promptly is an important aspect of service and good value. Health microinsurance models using a cashless system provide immediate relief to the client, and such systems would score highly on this indicator.

Table 34 Expense and claims ratios for selected schemes

<i>Micro-insurance scheme</i>	<i>Expense ratio (%)</i>	<i>Incurred claims ratio (%)</i>	<i>Comments</i>
CARD MBA	17	16 (credit life) 60 (whole life)	CARD MBA is extremely efficient, but not enough of these gains are paid back in the form of benefits, resulting in the rapid growth of its surplus – yet clients perceive the programme as excellent value. This cannot be expected to last indefinitely.
Spandana	4	91	Spandana combines low expense and a high payout ratio, which provides outstanding value to members.
MUSCCO	15	40	There is some value to clients, but after the scheme has built up reserves, it needs to improve the value.
AIG Uganda ¹	41	37	Poor value.
Delta Life	41	10	The combined high expense ratio and low benefit level raises doubts as to the long-term viability of this product.
Yeshasvini	10	140	The claims ratio is high because the plan received a government subsidy in 2004; it should decrease in the next year as the premium was doubled. The programme is still too new for an assessment of its likely future viability to be made.
AssEF	28	71	With these ratios, the programme has very little margin for building up reserves to protect itself from claims variation.

¹ These ratios only take into consideration the premium paid by the MFIs to the insurer, but not the additional fee retained by the MFIs to pay for their expenses.

4 Investment management

As discussed in Chapter 3.6, whenever there is an accumulation of funds, investment management needs to be such that it optimizes value. The incorrect management of assets is a major reason for the failure of commercial insurance companies. Microinsurers offering long-term asset accumulation products have to be extremely vigilant in managing their assets professionally.

Asset diversification and quality are the best ways to protect an investment portfolio and therefore both are important indicators for measuring sustainability. The **asset diversification** measure should reflect the amount invested in a particular asset including a related organization, whereas the **asset quality** measure should reflect the overall quality of the portfolio. For example, as a general rule no more than 10 per cent of assets should be in any one investment or in a related organization. Over-exposure to property is another danger since this will ultimately impair liquidity and make it difficult for the scheme to meet its claims and expense obligations in a timely manner.

CARD MBA and VimoSEWA recently had a high concentration of investments in a related organization, the loan portfolio of the parent MFI.⁵ This is a well-known danger, and both microinsurers are rated low in this category. Most of the case studies have very little information on asset diversification, asset quality and investments in general.

If the organization has given long-term guarantees, then it must have the capacity to carry out **asset-liability matching (ALM)**. This process requires projections of liability streams (claims, expenses, maturities, etc.) and the capability to periodically shuffle investments to ensure that the required investment returns are timed to coincide with future cash flow obligations. Failure to manage a portfolio with long-term guarantees in this manner can easily result in bankruptcy. If the scheme does not have the capacity, it should outsource investment management to a professional firm. Investment management performance should be monitored by means of qualitative indicators.

A microinsurer offering long-term interest rate guarantees must have ready access to quality investment instruments with matching term and interest rates to cover payment of the guarantees. In general, it should not offer long-term rate guarantees without ensuring that they are linked to actual portfolio performance (*see Chapter 3.6*). Indicators should be developed to monitor these practices.

⁵ Since the case studies were completed, CARD MBA and VimoSEWA have taken corrective measures and have significantly reduced their investments in related organizations.

5

Conclusions

Performance benchmarking is an important way for microinsurance providers to assess their development or for donors to understand their development requirements. Some of the more important indicators for preliminary assessment of a microinsurer's operations and practices are:

Marketing and distribution

- Participation rate
- Renewal rate
- Persistency rate

Financial management and viability

- Net income
- Solvency ratio
- Liquidity ratio

Efficiency and client value

- Expense ratio
- Incurred claims ratio
- Time to payout

Investment management

- Asset diversification
- Asset quality
- Asset-liability matching
- Matching interest rate guarantees

The aim of these indicators is to point to key areas that require management attention. Once a deficiency is found, further research is required to understand the source of the problem and to develop solutions that will improve results for future years of operation.

Besides these four categories, additional important indicators should also be developed in the areas of **risk management, legal and organizational structure, operations management, community outreach and health insurance**. The latter category should address some of the special challenges involved in offering health.

The authors have devised a fairly comprehensive preliminary set of 40 indicators over nine categories and the associated scoring mechanisms. Some of the well-known microinsurers discussed in this book were evaluated on a test basis using this set – the information was extracted from the CGAP case studies.

In the illustration below, each indicator was assigned a potential score in order to give it a weighting in the overall score. The total potential score for a microinsurer is the sum of the individual potential scores for those indicators relevant to or measurable for the microinsurer. Since not all indicators are applicable to or measurable for a microinsurer, the total potential score can vary. For example, a qualitative indicator measuring whether or not tariffs for services are negotiated with health service providers is only applicable to a health microinsurer – for microinsurers without a health product both potential and actual score for this indicator were set to 0. Similarly, in cases

where data was insufficient for the evaluation of a particular indicator, both potential and actual scores for the indicator were set to zero.

Without going into the methodology of scoring and the scoring formulae used, the ratings for the microinsurers in the case studies are summarized in Table 35.

Table 35

Rating of microinsurance schemes – An illustration				
<i>Microinsurer</i>	<i>Country</i>	<i>Potential</i>	<i>Actual score</i>	<i>Rating (%) score</i>
Yeshasvini	India	122	100	82
TUW SKOK	Poland	130	106	82
La Equidad	Colombia	86	70	81
VimoSEWA	India	86	65	76
Tata-AIG	India	89	66	75
AssEF	Benin	143	105	73
CARD MBA	Philippines	151	109	72
Columna	Guatemala	150	108	72
Grameen Kalyan	Bangladesh	132	92	70
UMSGF	Guinea	117	77	66
ServiPerú	Peru	109	70	64
Spandana	India	114	63	55
MUSCCO	Malawi	137	75	55
Madison	Zambia	77	41	53
Yasiru	Sri Lanka	117	55	47
Delta Life	Bangladesh	127	58	46
AIG Uganda	Uganda	79	35	44
Karuna Trust	India	59	26	43
TYM	Viet Nam	114	39	34

4 Institutional options

Klaus Fischer and Zahid Qureshi

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I Introduction

The majority of microinsurance providers in the world are mutual institutions of some sort. Mutual institutions are owned by their member-users and respect the “one-member, one-vote” principle.¹ Mutual institutions come in several varieties, including three that emerge from the case studies:

1. *Stand-alone mutual (or cooperative) insurance companies:* These are mostly large mutual insurance companies not affiliated to any network of mutual institutions. CARD MBA in the Philippines and Yasiru Mutual Provident Fund in Sri Lanka are examples of stand-alone mutuals.

2. *Insurance as a business affiliated to a network of financial cooperatives (savings and credit cooperatives or SACCOs):*² An insurance company is affiliated to a network of co-ops, usually savings and credit co-ops, and provides insurance services to members of the network.³ Most large networks of SACCOs also deliver insurance services to their members through such a sponsored insurer. Many of these insurers are members of the International Cooperative and Mutual Insurance Federation (ICMIF). This model is referred to as the cooperative or SACCO network.

¹ The expressions “mutual institution” and “mutuality” used in this chapter refer to both “cooperatives” and “mutual associations”. The technical differences between both these specific forms are discussed in Section 2.

² This chapter uses the term SACCO, which is more generic than “credit union”. The term “financial cooperative” is not used since it often represents both savings and credit and insurance cooperatives.

³ The term “network” applies to apex structures that bind many independent institutions by a long-term contract or alliance to pool resources. For example, SANASA (owner of ALMAO), one of the largest alliances in the world, is composed of 8,500 legally independent savings and credit associations.

3. *Networks of mutual insurance associations:* The network is composed of mutual insurance associations that create apex structures, such as Union Technique de la Mutualité Malienne (UTM); friendly societies associations also operate in this way. This model is also referred to as the community-based approach, which is discussed in detail in Chapter 4.3.

The main difference between the second and third categories is that, for the latter, the mutuals were created solely to provide insurance to their members, whereas for SACCOs, insurance is just an additional product, and often not even considered a core service. This chapter focuses on the second type – insurers for a cooperative network – which includes the institutions summarized in Table 36.

Table 36

Case studies that correspond to the cooperative network model

Country	Institution (# of affiliated SACCOs)	Start of scheme	Persons covered (data from)
Peru	ServiPerú (86)	1994	94 000 (2003)
Poland	TUW SKOK (1 285)	1998	93 000 (2003)
Guatemala	Columna (87)	1993	54 000 (2003)
Various	9 ICMIF member insurers ¹		
Malawi	MUSCCO (57)	1980	56 000 (2003)
Colombia	La Equidad Seguros (1 273) ²	1970	30 000 (2004)
India	Yeshasvini Health Care Trust (25 000) ³	2002	1 450 000 (2004)
Sri Lanka	ALMAO (8 500)	1991	50 000 (2004)
Benin	AssEF (137)	2003	2 000 (2004)
Togo	MAFUCECTO (68) ⁴	1989	n.a.

Notes:

¹ This case study, ICMIF (2005), “Lessons learnt the hard way”, covers nine institutions in eight countries. Confidentiality agreements do not allow disclosure of the names.

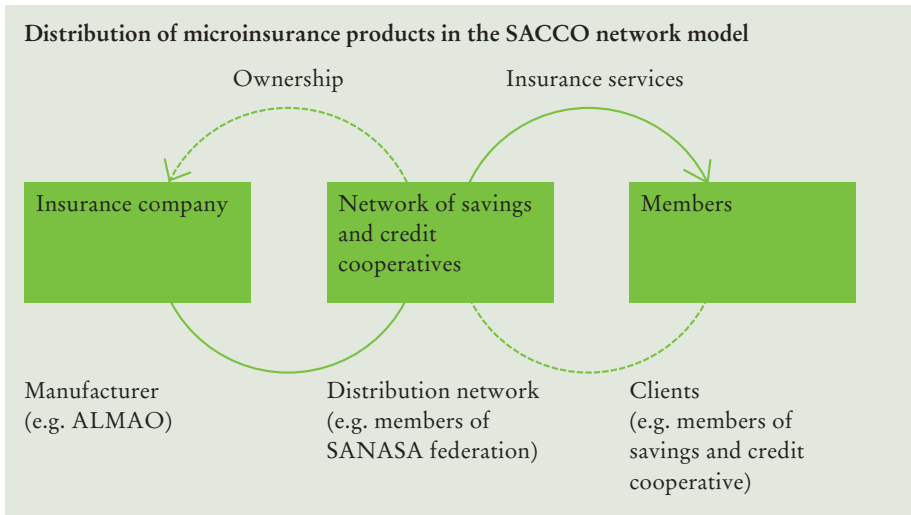
² This includes SACCOs and other cooperatives.

³ Cooperative societies in a wide range of businesses.

⁴ Pilot experience in Togo which if successful will be extended to SACCO networks in Burkina Faso, Benin, Mali and Senegal.

In the cooperative network model there are two key components: 1) a risk carrier, often an insurance company, which creates and underwrites the insurance products and 2) an association of cooperatives (financial and/or non-financial) that serves as the distribution network as well as a more-or-less captive market. Figure 23 illustrates this relationship in a simplified fashion, where the broken-line arrow represents ownership links and the solid-line arrow the flow of services. While the cases cover mostly SACCO networks, the model works just as well for other types of cooperative networks, such as agricultural and consumer cooperatives. Indeed, Yeshasvini is an example of microinsurance being provided through a multi-sector network.

Figure 23



In contrast to the partner-agent model discussed in the following chapter, this arrangement is not a joint venture between two independent organizations contractually engaged to offer insurance products. In the cooperative model, the insurance company is owned and controlled by the network and created for the purpose of delivering insurance services, to the network initially and then to other segments of the market as the company gets established. This distinction has important implications for the quality and cost of services provided to low-income segments (*see Box 67*).

While the main purpose of the insurance affiliate is to service the membership of the SACCO, it may also offer insurance products for the cooperatives themselves. For example, as described in Chapter 3.8, TUW SKOK was initially created by Poland's National Association of Credit Unions to provide deposit insurance and other corporate covers for the savings and credit unions; only after several years did the insurer introduce products for the SACCO members.⁴

Box 67

Why cooperative insurance suits low-income markets

In 1977, UNCTAD passed a resolution endorsing cooperative insurance. Referring to the study entitled *Cooperative insurance: A suitable form of insurance for developing countries*, it called on multilateral and other aid institutions to “respond to requests of developing countries for technical assistance in the promotion of cooperative insurance”. Among the study's findings are reasons why cooperative insurance is particularly suitable for low-income segments of the market:

⁴ In the case of Yeshasvini, the Trust is mainly controlled by the Department of Cooperatives rather than the co-ops themselves. Though a unique case, this experience illustrates that cooperative networks can be useful under a variety of contexts.

Affinity

A cooperative is essentially an organizational instrument for enabling small producers and consumers to pool their resources to secure the economic advantages of scale – as individuals, they essentially have no voice, but collectively they can achieve significant results. This principle is particularly applicable to insurance, which is based on spreading risks over as large a number of insureds as possible.

Accessibility

The cooperative organizational form covers many different sectors – including agricultural production, fisheries, marketing, processing, handicrafts, retailing, storage, transport, savings and loans, and home ownership. A cooperative insurer is in a position to cater for a wide range of basic needs and can reach farmers in remote rural areas as well as lower-income groups in towns and cities.

Affordability

There are many reasons why cooperative insurers can reduce their total costs, and hence premium rates, below those of private insurers. A cooperative insurer can dispense with a special sales force and with commissions; it may conduct a sales campaign for an entire village through an existing agricultural co-op, or direct-market various covers without agents through savings and credit cooperatives. Through use of the local society and network, premium collection and claims settlement procedures are simple and cost-effective.

Investment in community

Cooperative insurance facilitates savings and accumulation of capital in the lower-income brackets, and channels a portion of these funds into the local trade and industry, helping to improve living standards.

Ownership

Policyholders are also owners of cooperative insurance enterprises. The parliamentary structure stemming from cooperative principles offers them a real opportunity for direct control over decision-making. They have a special interest in health promotion and loss prevention, for their interest is not only in personal insurance but also in protecting the society's assets they jointly own.

Source: Adapted from UNCTAD, 1977.

The cooperative model takes this basic shape in most countries, developed and developing alike, where the cooperative movement has taken hold. What is more, the model is self-adjusting, adapting to the standards and requirements of the membership of the SACCO network. In networks dominated by middle-class people (e.g. southern Brazil's SICREDI), its products will tend to suit that market. If the network is rooted in low-income members, the insurance products will be adapted to that clientele. If the services are not adapted to its members' insurance needs, failure can ensue. For example, at ALMAO, regulatory restrictions are imposing a higher cost structure, which in turn has encouraged the design of higher-margin, up-market products that moved the insurer away from its clientele; not surprisingly, the products are not selling very well.

Decades ago, cooperative and mutual insurance took root for low-income people in what are now developed countries. In Canada, following the Great Depression when insurance for low-income households was inaccessible and unaffordable, two separate cooperative insurance schemes emerged, each bringing together savings and credit cooperatives, marketing/supply and consumer cooperatives, farmers' associations and trade unions. In many developing countries today, similar structures are emerging.

However, the model is not trouble-free. In some countries, a cooperative insurer may have the network's second-tier representation on its board of directors, but its microinsurance is run in concert with the managements and boards of only a handful of primary cooperatives in the network. This is the case of ServiPerú and La Equidad. Both have microinsurance programmes that are sustained in effect not by broad participation of the network, but through direct dealings with only a few network members. Moreover, La Equidad's sales of microinsurance through a non-cooperative MFI, Women's World Forum, were more successful than those through the participating cooperatives. These irregularities are often related to the particular history of the supporting network or the circumstances under which the insurance affiliate was created. If the governance structure is weak, the result may be management entrenchment and an outcome less adapted to the needs of co-op members.

The use of other distribution channels by a cooperative insurer may appear confusing and be perceived as a sign of independence from the cooperative network, but it is not so. It does not dilute the network's ownership, just as the use of multiple distribution channels by a privately held insurer would not affect its shareholding. Besides, cooperative and mutual insurers' forays into non-cooperative sectors usually involve affiliation with organizations that are like-minded and popularly based – operated with the interests of customers rather than those of shareholders at heart.

2

What is a mutual insurer?

There are two basic types of insurance company: joint stock and mutual. A **joint-stock company** is owned by investors, among whom profit is shared through dividends. A **mutual company** is owned by its customers. After deductions for reserves, profits are distributed to customer-owners usually in proportion to the business they did with the company.

Mutual insurers can be classified into three types. The first one requires neither a premium nor an assessment of policies. In this type of organization, also called post-paid, claims are charged to members after the event. This form was common in the past, but is nearly extinct today because members must be sought out after each event and the fulfilment of obligations weakens as social ties loosen. The second type has premiums and assessable policies, while the third has premiums and non-assessable policies. In the latter, policyholders receive dividends, but additional assessments are not levied for losses (i.e. they share the surpluses, but not the losses). Not surprisingly, regulators require higher levels of retained earnings and reserves for the third type. The second and third types are quite frequent today. Most mutual insurers covered in this chapter are of the third type; mutuals covered in Chapter 4.3 tend to be of the second type, with the members sharing the risks and returns.

In countries with a strong self-help and cooperative tradition, an insurance company or society can be incorporated as a **cooperative**. While both are self-help, self-responsibility and self-governance institutions, the difference between mutuals and cooperatives lies in the ownership structure. A mutual insurer must be owned by its policyholders. However, a cooperative insurer may be owned either by its customers or by cooperatives (second-tier institutions) that may or may not be its customers. In other aspects, such as marketing, community involvement, staff participation and welfare, mutuals and cooperatives have the same ethos. In some cases, a “cooperative” insurer will actually be a joint-stock company for the strategic or regulatory reasons discussed in Section 6 of this chapter.

Insurance companies adhering to cooperative principles have different roots in different countries, but share some characteristics:

- **Democratic control**, underpinned by education of the customer base, with policy-owners involved in governance through delegates and working groups
- **Limited return on equity**, patronage dividends and other cooperative principles

- **Affiliation of founding members** and most policyholders to social, community or professional institutions
- **Promotion** of health, safety and loss prevention to reduce the costs of insurance
- **Influence** over the insurance industry and policymakers in the interest of policyholders

3 The cooperative difference

How are these cooperative characteristics reflected in actual operations, and what sets the insurers apart? Here is a look at five of the cases in Table 36:

1. *ServiPerú*

Its microinsurance product, Previsión Familiar, provides funeral and health services to low-income households. Its benefits are in kind, in the form of a service (healthcare and funeral) through ServiPerú's own medical centre and funeral company, instead of a payment or reimbursement of expenses. This approach overcomes some of the market's inherent aversion to insurance, permits greater control over the quality of services, and helps accommodate specific characteristics of the microinsurance market. Besides door-to-door monthly premium collection to enhance accessibility, the cooperative has a service approach that treats the poor with respect. Low-income people who are used to being treated poorly in medical clinics are extremely appreciative of the consideration provided by staff at the Servisalud.

2. *Seguros La Equidad, Colombia*

This mainstream insurer of more than 3 million people has two specialized products covering some 30,000 low-income persons. It operates under the supervision of the Superintendent of Banks and is registered under the Cooperative Law. La Equidad distributes its surplus to its members based on their use of the insurance services, not on the basis of their capital investment.

The Cooperative Law requires that 20 per cent of any surplus be dedicated to education. In 1990, the company set up the La Equidad Foundation for the Development of Solidarity to carry out its community responsibilities in four areas: a) cooperative leaders' training, b) cooperative education, c) publications and d) social contributions. Cooperative leaders' training, targeting the youth, is designed to ensure that in the future the cooperatives are well administered by people with high professional skills and social values. Cooperative education is especially for board members of the organizations associated with La Equidad, focusing primarily on improving their performance.

3. *Columna, Guatemala*

When this insurer was created by the SACCO federation and nine member cooperatives in 1994, the board decided that any surplus generated during the first five years would be added to retained earnings rather than paid back to shareholding cooperatives as dividends. This was a difficult decision, as the cooperatives were invited to invest in the venture as a business opportunity and did not fully appreciate that an insurance company requires a lot of capital to grow. They wanted a good return. Since 1999, 50 per cent of the net surplus each year has been added to the shareholders' capital and the other half paid to them as dividends. This arrangement has strengthened the insurer while generating returns for its cooperative owners. Columna has also involved the sponsoring cooperatives in claims processing and product development.

4. *TUW SKOK, Poland*

This mutual insurer's mission is to identify the insurance needs of its members – cooperative savings and credit unions and *their* members – and provide high-quality insurance products which meet such needs. TUW SKOK provides credit unions with deposit insurance and loan protection, fidelity bonding, and coverage for robbery and fire; the insurer also provides credit union members with a number of personal insurance products. Deposit insurance offered by an apex affiliate is an unusual arrangement, partly due to the regulatory environment found in Poland. SACCOs are required to buy deposit insurance from TUW SKOK, which gives the insurer a guaranteed stream of premiums with no acquisition costs. Most credit unions also source other corporate policies from the insurer. As a mutual insurance company, TUW SKOK is not allowed to declare dividends. Surpluses are generally used to build up capital and reserves, but are sometimes remitted to credit unions in the form of premium refunds. In 2003, for example, TUW SKOK's board of directors, on behalf of its owners, decided to refund deposit insurance premiums to credit unions that had recorded satisfactory claims experience over the previous three years.

5. *MUSSCO, Malawi*

SACCOs were promoted by the church and government in Malawi in the 1970s to serve people ignored by commercial banks. In 1980, a national association, MUSSCO, was formed to provide support services to them, including mandatory loan protection and life savings schemes. Both of these are credit-union-pay products, which makes MUSSCO's system for premium collection effective. The premium for all eligible loans and savings balances for the 55,000 members is paid by the SACCOs quarterly in advance.

Though credit-union-pay products like these overcome one of the most significant challenges of microinsurance – collecting premiums from low-income people – MUSCCO has found that, in practice, collecting from even 57 corporate customers can be difficult. Only a third of the SACCOs can be described as disciplined customers; considerable time and effort has to be expended on chasing the remainder for payment. However, the insurance contract does provide for benefit payments to be withheld until the premium is paid.

4 Insurance development models and stages

The cooperative model of insurance actually involves different institutional and regulatory arrangements. Based on the experience in a variety of countries, Reinmuth et al. (1990) describe an institutional development plan in which the insurance services offered through the network to the SACCOs and their members become increasingly formal and complex over time, as the organization builds up capacity and human and financial resources. They describe three institutional options: the agency model, the risk-bearing department and an insurance company, which often represent different stages of institutional development for insurers serving SACCO networks.

4.1 The agency model

The SACCOs' national federation or affiliated organization could create an insurance agency that it owns and controls. The agency retails insurance products, which are provided by a local underwriter (i.e. a risk-bearing insurance company) or several underwriters. The agency provides services to members in its name and is paid a commission by the underwriter. The principal advantage of the agency model is that the federation does not bear any risk. An example is the NUCS (National Union of Cooperative Societies) Cooperative Insurance Services launched in Jamaica in 1984 with share capital provided by the Jamaica Cooperative Credit Union League.

4.2 Risk-bearing department

With experience as an agent for other insurers, it may make sense for the national federation to set up a department of its own to provide a group insurance scheme through member cooperatives. This step requires more capable staff, greater capital, cooperation with a reinsurer and, of course, acceptance of a degree of risk. However, with the risk comes the potential reward of a greater return. An example was the Mutual Protection Service of

FENACOAC, the national SACCO federation in Guatemala. This risk-bearing department offered covers for loan protection, life savings, funeral expenses, group life for directors and employees, family life, and fidelity bonding and theft insurance. The department was the precursor of Columna. MUSCCO's insurance scheme is currently structured in this way.

4.3 Insurance company

The services offered through a risk-bearing department tend to be quite basic. As the needs of SACCOs and their members evolve, however, they will probably require more complex coverage that can only be offered through a regulated insurance company. With an abiding commitment, financial means and realistic prospects of picking up business readily, a national federation may formalize this department by creating a fully fledged insurance company that meets all legal requirements, including minimum capital and approval of the superintendent of insurance.

For example, ALMAO's origins are linked to the insurance department of the Sanasa movement and an insurance brokerage set up to serve the needs of the Sanasa societies and their members. Without donor support, the movement was able to mobilize sufficient funds and expertise to create a life insurance company in 2002 and a general insurance company in 2005.

5 Insurance products offered under the cooperative network model

Mutual insurers offer practically every possible insurance product, but most of these multi-line insurers, like ICMIF members, do not focus on the low-income market. Specific networks of mutuals serving the poor tend to offer only a few or perhaps even a single product. At that end of the spectrum, mutual health organizations (MHOs) specialize in health insurance, while at the other extreme, some mutuals may offer a product menu resembling that of an investor-owned insurance company.

In general, the range of products being offered to the low-income market through SACCOs is limited. The original intention of SACCO networks for creating insurance affiliates was to complement the range of financial services they offer, namely savings and loans. This implies that loan protection, or credit life (ensuring that "the debt dies with the debtor"), is almost always offered under this model (see Table 2). This product serves the risk needs of both individual members and the SACCOs themselves. Life savings coverage is another key product offered by SACCOs because it too corresponds with the co-ops' core services.

Another reason why the microinsurance product menu of some SACCO network insurers is limited is that these schemes were often seeded and supported by technical assistance providers, including CUNA Mutual, that chose to promote very basic and simple coverage. This choice made sense, particularly given the limited development of the SACCOs' networks. In addition, offering the same basic products everywhere was an efficient replication strategy. Where the networks and its insurance affiliates have been able to build up the capacity to do more, such as in Colombia and Poland, the basic products serve as a foundation for more useful covers; whereas in Malawi, where capacity remains limited, the network has stayed with the basic package.

The evolution expanding the line of insurance services is important not just because the insurer is addressing a variety of different needs, but also because it can improve the relationship between the insurer and its distribution network. An interesting distinction exists in the cooperative insurance model between cover that is paid for by the SACCOs and member-pay products. Although SACCO-pay products such as loan protection and life savings are an extremely efficient way of providing protection to low-income households, some SACCOs come to see the premium as an expense that they would prefer not to pay – which may partly explain why many SACCOs in Malawi have delinquent premiums. Consequently, it is important for insurers to consider introducing member-pay products that can generate commission income for the SACCOs, which enhances the alignment between the interests of the insurer and the distribution channel.

The alignment of interests is particularly effective when the member-pay product supports a savings or credit product provided by the SACCO, such as the savings completion insurance provided by TUW SKOK (*see Chapter 2.2*). Not only does the SACCO earn income from insurance sales, but the insurance feature helps to market the savings product. In contrast, the only example of endowment products offered by the cooperative network model is ALMAO, and it is not particularly successful with these products. One explanation for the lack of success is that, with such a product, the insurer is essentially competing with the SACCOs for the members' savings – a conflict of interests rather than an alignment.

A particular feature of the mutual model is the ongoing dialogue between the insurer and its distribution channels, which are also (often) its owners. For example, Columina performs annual reviews of insurance sales by the SACCOs that provide an occasion for dialogue about new products and changes that could be introduced. Offering a variety of insurance products has a number of advantages for SACCOs: it encourages the cross-use of

products, increases fidelity and generates commission revenues (if it is a client-pay product for which the SACCO acts as a sales agent).

Table 37

Insurance products offered by SACCO networks

	<i>Loan protection</i>	<i>Life/Life savings</i>	<i>Funeral service</i>	<i>Health</i>	<i>Disability</i>	<i>Other</i>
ServiPerú	x		x	x		x
TUW SKOK	x	x	x		x	x
Columna	x	x			x	
MUSCCO	x	x				
La Equidad	x		x		x	
Yeshasvini				x		
ALMAO	x	x	x	x	x	x
AssEF				x		
MAFUCECTO	x		x			

6 Why mutuals develop networks and how they work

Most mutual financial intermediaries (deposit or insurance) are associated with a macro or inter-mutual organization. Often they organize complex alliances capable of offering a range of financial products. These alliances are institutional devices to control the market risk facing the mutuals' members. Inter-mutual alliances are so vital that they may serve anywhere between a few thousand to a few million members and offer a surprisingly rich range of financial services. The size is very important for (i) the performance one can expect in terms of outreach and sustainability and (ii) the role of the legal and regulatory framework for inter-mutual alliances. Countries with large, successful networks are typically places with a supportive legal and regulatory environment.

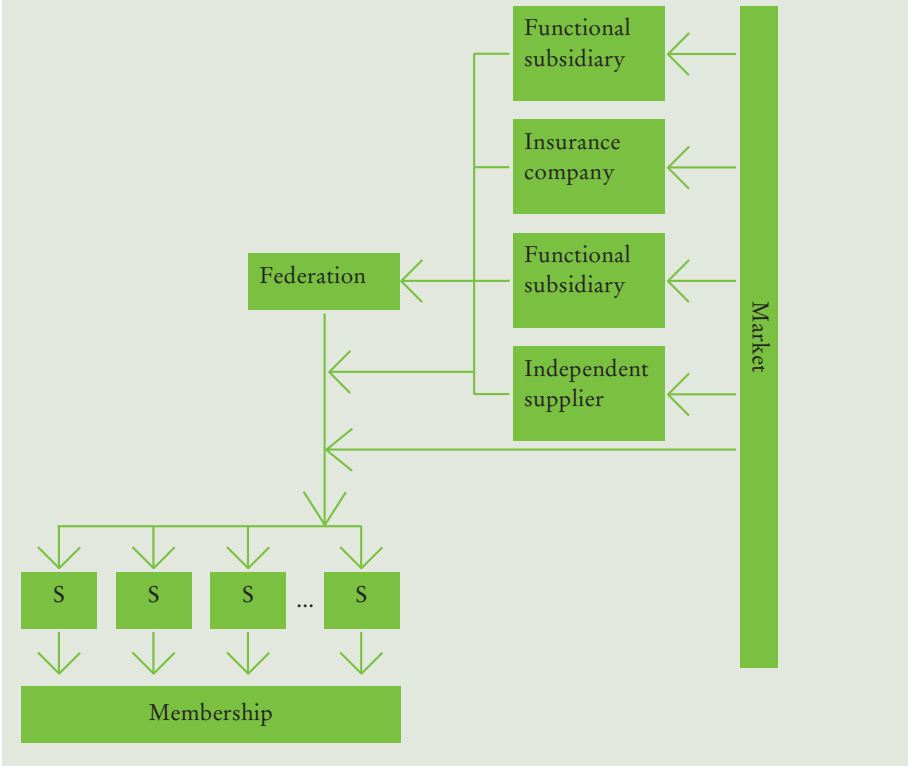
Mutuals create alliances and form collectives (also called federations, unions, etc.) to give members a greater voice in and control over the uncertainty associated with accessing services. Without this collective effort, the members have limited bargaining power with suppliers, leaving them to face expensive and low-quality products and the risk of opportunistic behaviour on the part of the suppliers. Thus, they create a "supply alliance".

Figure 24 provides an illustration of the institutional structure (where "S" represents a SACCO). The members of the cooperatives are owners of the entire structure. The cooperatives in turn form a federation to manage the pooling of resources and procurement of inputs required by the network. To accomplish this, the apex creates functional subsidiaries, such as an insurance company, designed to create products and services for members that are

more favourable than those available in the market.⁵ For some inputs, the apex pools procurement through a long-term contractual arrangement and gains economies of scale while protecting members from the risk of opportunistic behaviour on the part of suppliers.

Figure 24

A mutual network structure with its portfolio of functional subsidiaries



The ownership of the subsidiaries varies. Sometimes it may be a cooperative (e.g. La Equidad), in which case it is considered a third-tier cooperative. At the primary level, a SACCO has individual members. The second tier has a regional or national association serving a number of primary cooperatives. This apex body – or bodies, if cooperatives in sectors other than savings and credit join in – sponsors and controls an insurer on behalf of member cooperatives.

⁵ In countries where the sophistication of financial markets puts more pressure on the network, the portfolio of functional subsidiaries may include dozens of entities, held in all sorts of ownership and holding arrangements. As demand for financial services at the base of the system (members and cooperatives) evolves, the apex will typically incorporate additional functional subsidiaries. Equity for these investments will generally be provided by the cooperatives at the base or by other functional subsidiaries that may have surplus capital available.

The use of joint-stock ownership is becoming increasingly popular (e.g. ALMAO, Columna). In fact, many “mutual” and “cooperative” insurance companies actually have joint-stock ownership, but are referred to as mutuals because their ultimate owners are not individual investors but mutual institutions. The joint-stock form is appealing because of its flexibility in raising capital and for engaging in mergers, acquisitions and joint ventures. These transactions are all useful in expanding the range of products offered to members if the need arises. Also, the joint-stock option is sometimes the only ownership structure the regulatory framework allows (for example in Peru and, ironically, in China and Russia). The risk is that, as these companies grow, they may forget their roots and behave like normal stock companies. In doing so, they risk the loss of their comparative advantages of proximity and putting members/clients first. This sometimes poses a challenge in terms of governance and ensuring that the insurer remains committed to serving the specific needs of the SACCO network members.

Other variations are possible. When a new insurance law in Peru (1993) barred cooperative institutions from offering insurance, the insurance company of the Peruvian SACCO network, SEGUROSCOOP, transformed itself into ServiPerú, a cooperative offering social services (funeral and health protection services). It transferred the insurance portfolio to a joint-stock company and created a subsidiary insurance broker to distribute products that it helps design. Taking advantage of adversity, the insurance affiliate managed to keep the same line of business despite regulatory obstructions while expanding its product line (the social security services).

More recently in Ghana, when the regulator called into question the informal risk management programme of the savings and credit cooperatives, the apex formed a joint venture with a newly registered and licensed cooperative insurer, Unique Insurance Company Limited, owned and controlled by the trade union movement. The insurer, underwriting the cooperatives’ risk management programme, lent it the required compliance while gaining a new market segment. This was essentially a partner-agent arrangement. What made it cooperative was the venture’s ownership. The insurer and the cooperative apex opted for a 50/50 sharing of the venture’s expenses as well as profits, with a joint management group overseeing the programme. The savings and credit cooperative apex had stepped out of its umbrella cooperative network, and so had the trade-union-sponsored insurer, to create a distinct, microinsurance-led network of their own.

These variations illustrate the flexibility of the cooperative network model to adapt to a diversity of economic and regulatory environments, without changing its essence. The organizational design of a particular institution will depend on the history of the SACCO network, how the affiliate

was created/acquired, regulatory restrictions and opportunities available in the marketplace.

The basic organizational structure of a network, regardless of cultural or economic context, replicates the governance features of a mutual at a second level. The executive structure comprises governance (general assembly and board of directors) and regulatory (supervisory committee) bodies. The executive structure (bureau) is responsible for implementing decisions and managing the procurement and delivery of inputs to members. In these structures, individual policyholders are removed from ownership, but are often assured of a voice through a dedicated channel in the democratic control structure. For example, a policyholder advisory committee brings together representative members to receive progress reports, provide input on specific matters and review forecasts on financial results and expected patronage dividends. In addition, some cooperative and mutual insurers may allocate a seat on the board for a policyholder representative.

The analysis of the dynamics of network formation in mutual institutions has important policy implications:

- Attempting to create mutuals without supportive network structures can lead to mediocre results. Individual SACCOs would ordinarily be unable to raise capital to create an insurance company to serve its members. Thus, unless the SACCO is part of a network, the benefits described in this chapter are unachievable.
- When mutuals are created with an integration structure that supports their development, they have the potential to become impressive market players, covering larger numbers of people and thus expanding outreach. Furthermore, these support structures improve sustainability and reduce insolvency risk. For example, TUW SKOK's deposit insurance benefits significantly from the fact that the national association of Polish credit unions closely monitors the performance of its members and has a stabilization fund to assist SACCOs experiencing difficulties.
- Mutuals and their network structures need an appropriate legal framework. Indeed, many SACCO networks operate in unsuitable environments that hamper the development of mutuals and their networks, such as Argentina and Uruguay where the regulatory framework led to the destruction of the networks' structures followed by a massive reduction in market share. Many of the difficulties encountered by ServiPerú's predecessor in the 1990s are due to the unsuitable regulatory framework that emerged in the post-crisis reforms.

7

Advantages and disadvantages of the model

This section presents the main lessons relating to the delivery of microinsurance through the cooperative model. Mutual institutions have weaknesses. There are literally hundreds of thousands of them in the world, and so there is bound to be more than just a few failing to deliver. However, most problems are remediable, if not avoidable.

Some of the most significant **problem areas** are:

1. The poorest of the poor may not always benefit (but often do).

This is a classic criticism of the cooperative model. Mutual institutions are the chosen financial intermediary of a very large range of social sectors, sometimes reaching quite high up the income ladder. However, mutual institutions are also found at the bottom of society and reach hundreds of millions of people who do not have access to other financial institutions, particularly in rural areas where even the most aggressive alternative institutions are often absent. This feature in fact allows mutuals to cater for poor segments of the population without necessarily compromising their own sustainability. The frontier of their outreach is defined by their ability to activate their members' potential to help themselves.

2. Insurance products may be too limited as they tend to be tied to credit products.

This is largely true, particularly in networks that are relatively new, with a low level of integration, or few financial, human and technical resources available (e.g. Columna, MUSCCO, MAFUCECTO). As integration and trust among co-ops develop,⁶ financial resources and technical expertise accumulate, allowing the network to expand the range of financial products, including insurance. The range of products offered by La Equidad, for example, rivals that of commercial insurers in Colombia (although the case study only describes those products distributed to the low-income market).

3. Leaders may be inclined to squander member capital.

There is no direct evidence of this behaviour in the case studies, with the exception of the criticism advanced in *Lessons learnt the hard way* (ICMIF 2005). Indeed, it is not unusual for a SACCO network to have a frail

⁶ This usually involves the development and financing of network governance bodies and control mechanisms that ensure that the network members' conduct is in accordance with the terms of the alliance.

governance structure. This results in weak control of agents (managers) at the apex and they may thus engage in expansionist practices with little regard for protection of the members' wealth.⁷

4. The success of a mutual insurer is tied in with the success of the cooperative network.

This is unavoidable, since the very *raison d'être* of the "functional subsidiaries" is to service the network. While it is not unusual for them to develop some business activity outside the network, it usually represents only a fraction of turnover. The bulk of business tends to remain within the network. ServiPerú is a case where the microinsurance service provider survived a severe crisis of its supporting network in the early 1990s.⁸

5. Risks may not always be properly separated (firewalls).

This can be a severe problem that must be addressed by regulators. In the absence of appropriate supervision, there may be a temptation to mix credit and insurance risk resulting in a high likelihood of failure. MUSCCO is a case where separation is weak and it could break down under stress.

6. Entering into dangerous business uninformed.

While not specific to networks of SACCOs, this must be prevented. If the network is small, it may not be able to raise the necessary funds to acquire the required skills, such as actuarial services. Company 4 (in ICMIF 2005), a "worst practice" example, was set up as a SACCO insurer, but ended in failure. MAFUCECTO has had a bumpy history, enduring several restructurings with international support. While the solution to this problem does not lie with regulators, they can play an important role. As in the previous problem area, the regulatory framework should ensure that insurers are created after consideration of all risks and under the leadership of qualified individuals.

However, the model does have some eminent **advantages**:

1. Low "hold up" risk for insured individuals.

Hold-up risk refers to the possibility that a contractual party may fail to meet its obligations. Poor people are particularly vulnerable to hold-up risk

⁷ This is known as "expense preferences" behaviour or "agency costs". The severity of this phenomenon in mutual institutions – largely due to the high diffusion of ownership, and at the root of most failures – is well documented in the research literature.

⁸ This crisis resulted in the failure of the network's central cooperative bank, other functional subsidiaries and several of the largest S&L co-ops. It led to a fall in assets in the networks of nearly 50 per cent.

because of low social capital and the inability to defend their rights in courts. The fundamental difference between an insurance contract offered by a joint-stock company and that offered by a mutual institution is that in the latter, the insured is also the owner of the insurance enterprise. While investor-owned insurance enterprises may stop offering services, engage in discrimination and even resist honouring claims when they see fit to do so for strategic reasons, these practices are limited in a mutual institution. It is not a matter of ethics, but of basic economic incentives (*see Box 68*). Ownership of the insurer by the insured serves to control the insurer's actions so that they are aligned with the interests of the members/owners.

Box 68

Management of lapses and claims: The mutual difference

To illustrate the differences in incentives, consider the dilemmas facing Delta Life, an investor-owned insurer, and MAFUCECTO (and other mutuals). According to McCord and Churchill (2005), Delta Life has an “ambivalent attitude” to lapses. While the company is committed to social objectives, it benefits financially from lapsed policies where there is no obligation to repay the accumulated savings. Furthermore, the lapse allows the company to screen periodically the insured customer by requiring a new certificate of health. Thus, owners and staff face the contradictory objectives of profits and customer service. Under financial stress, it is likely that the balance will tilt in favour of protecting shareholder returns at the expense of customer benefits.

MAFUCECTO prevents lapses through automatic deductions from members' accounts. So do La Equidad (by debiting the loan or savings account, or through direct wage deposits) and TUW SKOK (debits to accounts). Obviously this is an advantage associated with the model of combining savings and credit with insurance products. However, even in the absence of this link, mutuals treat lapses differently. MHOs (covered in Chapter 4.3) do not use lapses to screen clients. Lapsed members may have to enter a new waiting period, so as to prevent opportunistic behaviour by members who may seek to manage lapses strategically, but they are not re-screened. In fact, lapses in an MHO, instead of procuring a financial advantage, represent a key instability factor.

The same is true of claims management. At Delta Life, when a death occurs, the beneficiary is responsible for notifying the insurer. In the case of MAFUCECTO, the SACCOs seek out beneficiaries to inform them of their rights and help them in the preparation of claims.

This exceptional behaviour has little to do with business ethics and much to do with the fact that members own and govern the institution. The general assembly of the SACCO would not have condoned any other behaviour than that of seeking out the best interest of the owners. This interest implies

not encouraging lapses, but preventing them, and not ignoring failed claims, but seeking them out. This duality of incentives is accentuated in poor communities where profit margins on individual policies offered by investor-owned firms are very small, and where individuals have no means of enforcing contractual rights. In a mutual institution, even in poor communities, the member, as owner, is always right. The board of directors of MAFUCECTO is composed of members of the board of directors of the SACCOs (themselves members of the cooperative). Thus, throughout the governance structure, the interests of the members are protected (but see problem described under 3, on page 351).

2. Potential access to large numbers of people in a large variety of cultural and economic environments.

Often SACCO or other cooperative networks can be quite large, reaching from tens of thousands to millions of people through member co-ops. Yeshasvini was able to reach 1.6 million clients in just a year! Furthermore, the presence of the model in every continent demonstrates its versatility in adapting to different cultural and economic environments. Owing to the large potential and “captive” customer base, insurance companies can exploit economies of scale (which was one of the main purposes of creating affiliated insurance companies), achieving break-even and becoming viable quickly.

3. Availability of risk capital for investment purposes.

Equity for the creation of insurance affiliates is from the members of SACCOs, financed either through a direct investment or by ceding capital to an apex, which in turn invests in the insurance affiliate. SACCOs tend to accumulate a surplus of liquidity and capital as they mature, particularly if they are operating in a healthy economy. Thus, these networks constitute an excellent source of risk capital to finance insurance and expand the range of services provided by the SACCOs. In eight out of the nine cases presented in Table 37 (Yeshasvini Health Care Trust, a foundation, is the exception), the start-up capital of the insurance affiliates was provided by SACCOs, with or without some external participation. On the other hand, mutuals cannot raise capital in the stock market. However, there is no restriction on joint ventures or the issue of bonds.⁹

⁹ This is a complex debate. A stand-alone mutual cannot issue stock, which limits the growth potential of mutual insurers. However, when the insurance enterprise is an affiliate of a SACCO network, its ownership structure can be adjusted to suit different financing options. Most networks have chosen not to list affiliates in the stock markets, but some have, thereby leveraging network-generated capital. Usually the network keeps a controlling share of the voting stock. Thus, joint ventures appear to be a more flexible form for leveraging capital from SACCO networks.

4. *Limited need for donor funding other than technical assistance.*

In connection with the previous point, the SACCO network can often provide capital to create/acquire the insurance affiliate, provided the regulatory framework does not put the minimum capital requirements out of reach of the network. External funding in these cases may be welcome as a joint venture, especially if this comes with technical support, as was often the case with CUNA Mutual,¹⁰ but funding is not essential. However, donors can make a big difference by providing technical assistance to train staff in the complexities of managing an insurance enterprise. This has been the case of Columna, for example, where technical assistance from, and strategic partnerships with, SOCODEVI and AAC/MIS have been a key element in the company's development, and MAFUCECTO where DID and CIF have played essentially the same role (see Chapter 5.5).

5. *Investments have a development effect as income returns to the community.*

Since the equity of the insurance affiliates is held by co-ops – either directly or indirectly through the apex – the funds generated by the insurance activity are eventually returned to their members. As the size of the portfolio of functional subsidiaries increases, so do the network's assets. If these assets are managed prudently, the cash flows they generate will be used to benefit the network and its members. For example, because of regulatory restrictions, TUW SKOK cannot pay dividends to shareholders. Although some profits are remitted to the SACCOs in the form of premium refunds, the insurer has also built up sufficient capital to buy a life insurance company and thus expand the range of services to its members.

6. *Access to reinsurance.*

As described in Chapter 5.4, access to reinsurance is a serious constraint for many microinsurance providers. However, those that provide microinsurance through SACCO networks have the necessary know-how to access reinsurance through upstream alliances. ICMIF has played a central role in facilitating access to reinsurance for its member networks. Therefore, most mutual insurance structures are likely to have access to some reinsurance in international markets – usually, but not exclusively, with other mutual insurance firms in the world.

¹⁰ For example, in 1993, CUNA Mutual and the Foundation for Polish Credit Unions (FPCU) launched Benefit, a joint venture that provided loan protection, life savings and funeral insurance. Along with technical assistance, CUNA Mutual provided 90 per cent of Benefit's initial capital. After four years of operations and moderate success, the partners decided to go their separate ways. However, by then, the Polish credit unions were well on their way to developing the impressive portfolio of insurance products they offer today.

8 Conclusion

Mutual insurance firms are ubiquitous and versatile institutions. This chapter focused on one type of mutual model, in which a network of savings and credit cooperatives creates its own insurance company (or agency, or a department of the network) to meet the insurance needs of the co-ops and their members.

The following features can be gleaned for insurers affiliated to mutual networks: i) the model appears frequently and in a wide variety of cultural and economic environments; ii) except for a few minor variations in organizational structure, often conditioned by local regulatory constraints, the examples present a constancy of operational characteristics and institutional arrangements; iii) by and large these structures work free of any subsidy; iv) institutions often have access to reinsurance, addressing a common problem for microinsurance providers; and v) while the examples are based on financial cooperatives, this model works similarly for other types of cooperatives as well.

Not only is the SACCO network model financially viable, but it is robust and potentially applicable to providing microinsurance services to poor people in a wide range of situations. Overall, the SACCO networks are versatile mechanisms for delivering various insurance products to relatively large numbers of people. However, individual structures tend to specialize in insurance products that complement the SACCOs' savings and loans portfolios. This is one of the weaknesses of the model. Another risk is that large companies may forget their roots and behave like stock companies, losing their comparative advantage.

These conclusions suggest that this organizational form is suitable whenever there is a network of savings and loans cooperatives on which to build the insurance business. Given the potential of the model, it would make sense to exploit its strengths and minimize its limitations, for example by developing clear guidelines for business plans that include financing modes, enhancing governance arrangements (links between the network and the insurance business), creating firewalls and developing insurance products, capacity and reinsurance products, that would provide SACCOs with competitive advantages. This chapter touches on several of these points, but more work is needed in this domain.

The partner-agent model: Challenges and opportunities

Michael J. McCord¹

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For as long as there has been insurance, there have been agents to sell it. The agents selling “industrial insurance” at factory gates in American cities in the early 1900s made the Metropolitan Life Insurance Company the largest company – not just insurance company – in the world at that time. Industrial insurance was essentially the forerunner of today’s commercial microinsurance. The transition from collecting premiums at the factory gates to group policies significantly enhanced the cost-effectiveness of the coverage. To reach the historic target market, employers became key players in bundling premium payments for the insurer, and ultimately even providing the coverage as an employee benefit. However, for today’s microinsurance target market, workers in the informal economy, group policies have to find a new delivery channel.

Such an option emerged when microfinance institutions began to identify insurable needs among their clients, since MFIs have financial transactions with large volumes of low-income people. Some MFIs turned to insurers, offering to act as intermediaries, and thus allowing their clients efficient access to insurance products. Seeing this as a low-risk, cost-effective way to enter a new market, insurers have also shown interest, at least in terms of basic products. Thus, the partner-agent model is simply a logical extension of a business model that has been used by insurers for the past century.

This chapter reviews the challenges and opportunities of using this agency model to deliver microinsurance to low-income households efficiently. In many ways, the partner-agent model is similar to the cooperative model discussed in the previous chapter, with a regulated insurer offering products through an institutional agent. The key difference is the ownership structure of the insurance companies. Credit unions own the insurer, while with the

¹ The experiences described in the chapter of Compartamos (Mexico), CARE and GLICO (Ghana), Constanta and Aldagi (Georgia), K-Rep (Kenya) and Kashf Foundation (Pakistan) are drawn from the author’s experiences, not from the case studies.

partner-agent model, the agents (frequently MFIs) are merely linked to the insurer in a contractual relationship.

The partner-agent model can be applied to different delivery channels. So far, it has most commonly been associated with MFIs, but more is being done to generate effective links with other channels such as retail shops, post offices, and even with prepaid phone cards. This chapter focuses generally on MFIs as agents and the experiences they have had with insurers. Chapter 4.6 describes partnerships between insurers and retailers as distribution agents.

1 Why a partner-agent model?

Critical components of successful microinsurance are efficient transactions and operations. If efficiency cannot be improved, the only way to reduce the premium costs to affordable levels is by reducing coverage. Providing a good product at an affordable price therefore requires efficient, yet controlled, processes. The key to efficient processes is the interface with the policyholder. This relationship defines the efficiency of sales, premium collection, information dissemination, and, in many cases, claims processing. The strength of the partner-agent model is that the agent, usually a microfinance institution, generally has an existing effective interface with the low-income market that can enhance efficiency.

Beginning as microcredit in the 1970s, microfinance became a global phenomenon in the 1990s once managers developed sufficient expertise to lend to the poor on a sustainable or profitable basis. Building on this firm foundation, managers began to express an interest in expanding their product lines. One particularly common scenario for MFI managers was to see a client do well for the first few loan cycles, only to then fall back into financial trouble. Research showed that when clients were having difficulty repaying their loans, it was often because of idiosyncratic financial risks such as a death or illness in the family. For organizations that used group-lending methodologies, a personal crisis affecting one member could undermine the cohesion of the group and contaminate the quality of several loans.

Several MFI managers recognized that insurance might reduce the impact of these problems. Some MFIs focused on protecting their portfolio through insurance; others also wanted to aid their clients and their families in difficult times. The decision then was to find a mechanism to insure their clients without distracting management and staff from their core products.

While some organizations decided to self-insure, for most, the choice was easy: turn to commercial insurers who already have mechanisms to address

these issues.² As many have found since, this model is usually the simplest, cheapest and quickest way for an MFI to start offering risk-management services outside traditional credit and savings products to its clients. As a bonus, this can be done with little additional risk for the MFI. An expanded product line, a source of fee-based income, protection for the MFI and its clients, little risk and virtually no financial input – how could it get any better?

Insurers in these arrangements get instant access to potentially tens, even hundreds of thousands of low-income policyholders, usually through a single group policy. Though some were reluctant at first, in many places insurers now actually compete to serve MFIs and their clients. Indeed, when Compartamos in Mexico was looking for an insurance partner, its three finalists were all major international insurers who fought hard for the business.

This model is also beneficial for low-income policyholders. They gain access to professionally-managed insurance products, to which they would otherwise have had very limited access. For clients of large MFIs, sheer numbers should allow the clients some control over product design, and the premiums should be more favourable. Finally, if there are disputes, the MFI is there to support them, rather than the low-income policyholders having to pursue the insurer to enforce the policy coverage.

This model clearly has the potential to be beneficial to all parties and can indeed provide a win-win-win situation. However, in many partnerships, there are still issues that need to be addressed to optimize the benefits for all parties, especially clients. Indeed, there are situations where clients could gain far more from this model, yet it is insurers and agents that are benefiting. The next sections will look at how the model is implemented and where some of the problems with it lie.

2 How the partner-agent model works

2.1 Selecting the partner

Unlike traditional agents, who are provided with a set of products developed by the insurer to sell to the unsuspecting public, MFIs have usually identified a need among their clients, translated that into a prototype insurance product, and approached insurers. The product concept often proposed to insurers includes a price range that clients would be willing to pay, and insurers are left to review the possibility of offering the product.

The bidding process used by CARE in Ghana (*as in Box 69*) has proved to be an effective way for an MFI to get the product that it wants under the

² See Chapter 4.7 for a summary of the advantages and disadvantages of self-insurance for MFIs.

most appropriate conditions. ASA in India also used the tender method, and sought insurers that would allow ASA to conduct the claims verification and pay clients directly, since the MFI had experienced significant problems with late and rejected claims with previous insurance partners. It sent out an invitation letter to a dozen insurance companies and received bids from almost all of them, perhaps because the letter said, in bold, “we have about 45,000 clients”. Interestingly, ASA chose to work with three insurers with nearly identical products, each covering a different geographical area. Although managing the three relationships involved more work, ASA preferred this solution because it created competition among the insurers. If one was underperforming, the MFI could seamlessly phase it out and transfer those clients to one of its other insurance partners.

Box 69**Selling an insurance concept in Ghana**

CARE conducted supply and demand research into offering microinsurance through rural banks in Ghana. It then brought all interested rural banks and insurers together for a one-day workshop to explain the results and the product concept itself. After this, CARE sent a tender offer out to all insurers. The interested insurers responded with their premium rates for the products demanded (as well as other specific requirements). CARE then used an assessment grid to select their ultimate choice – Gemini Life Insurance of Ghana (GLICO). The process generated much interest from the insurers – 12 insurers and brokers attended the original meeting and eight submitted responses to the tender offers – and certainly provided better results for CARE.

Source: Adapted from McCord, 2004.

Designing the product and the processes in this manner helped CARE and ASA obtain just what they wanted. Since their product concept directly reflected their clients’ needs, the clients were well served.

Many have argued that insurers will not accept a product concept that is developed by an institutional agent like an MFI. Certainly there are some insurers that are not interested in microfinance institutions or low-income clients, but these represent a minority. The experience of many MFIs has shown that if an insurance company is presented with compelling market research and an argument based on a sound understanding of insurance, then a specialized product will be accepted. Of course, the insurer evaluates and sets the premium, and may adjust the product to address specific institutional issues, but ultimately the product must respond to market demand as

represented by the agent. This is a common mode of operation for insurers working with insurance brokers.

2.2 Selecting the agent

Five years ago, the most common way for these relationships to emerge was for an MFI to approach insurers with a product concept. Today, however, some insurance companies are recognizing that this is a market that can be served, and they have proactively sought out potential delivery channels, including MFIs and other organizations that have financial transactions with the low-income market.

For insurers, finding an appropriate agent is also critical to success. Since the agent is the face of the product, its role in convincing prospective policyholders to purchase insurance is pivotal. Poor selection of agents can lead to serious delays in growth, bad public perception and dramatically higher costs.

Insurers want delivery channels with many clients, potential for growth, a strong reputation for customer satisfaction and a commitment to insurance at the board and management levels. Partnerships are more successful if the agent has a computerized MIS and a strong training function. Certainly, insurers are happiest when they can offer group products through one master policy for the institutional agent such as an MFI, a labour union or other large group of low-income people, and when the product is mandatory.

When initiating the search for an appropriate agent, the insurer must remember that its own ability to recognize poor households as a separate market requiring distinct products is crucial to success. Insurers need to be willing to alter their standard products – or better still, develop new products from scratch – to suit the characteristics of the low-income market.

In some jurisdictions, insurance agents need to be licensed; in some cases, agents cannot be organizations, but must be individuals. The licensing process may involve a certain number of hours of training and/or passing an exam. These requirements are often not conducive to officially registering an MFI or selected staff members as agents, and therefore an appropriate means of complying with insurance regulations needs to be explored (*see Chapter 5.2*).

2.3 Clarifying roles

Once the product concept is developed, and the insurer and agent have identified each other, it is important that the parties identify the roles they will play in the microinsurance process. Formal agreements or **memorandums of understanding** (MOUs) will minimize future disagreements, foster a

smoother working relationship and form the foundation for governing relationships.

In developing the agreement, each party must understand the various components of insurance delivery and agree on where the responsibilities lie. Some of the elements clearly fall to one party or the other. Regulatory reporting lies with the insurer, just as premium collection lies with the agent MFI. Other elements might not be as clear. Key responsibilities that must be addressed within an agreement are described below.³

Underwriting

To maximize the efficiencies of this model, underwriting is typically carried out in the course of the claims verification process. In this case, a sort of underwriting takes place simply by virtue of a policyholder's ability to conform to the policies and requirements of the organization through which it purchases the insurance. For example, AIG Uganda takes every policyholder provided by the MFIs. There are no restrictions to entry other than the ability of a person to join one of the many MFIs in Uganda. One of the main advantages for insurers to collaborate with an MFI, as opposed to an organization that does not lend, is that its credit screening can be a substitute for life insurance underwriting. Chapter 3.4 discusses in more detail the importance of shifting underwriting from the initial application phase to the claims end of the process.

Staff training

Generally, the agent's frontline staff members require training in insurance principles, insurance marketing and the details of the particular product. This training can be provided directly by the insurer. Alternatively, the insurer can help develop the training materials for the MFI's training staff to deliver. La Equidad in Colombia, for example, has developed a special programme to train the credit analysts of its agent Women's World Foundation (WWF). WWF invests an average of two days on insurance out of 45 days of training for new credit analysts using the programme designed by La Equidad. Other staff need training and guidance on such issues as scheme administration and MIS applications.

Premium collection and remittance

As highlighted in Box 70, the premium collection process is extremely detailed. This process must be documented so that each party is clear on the

³ A comprehensive list of insurance activities that should be part of a partner-agent agreement can be found in Churchill et al., 2003.

timing and its role in the process. Efficiency is critical. Since MFIs already have financial transactions with their clients, it is relatively easy for them to collect premiums as part of loan payments or from policyholder savings.

Box 70

Partner-agent premium collection checklist

- When do clients pay the premium?
- When does the agent remit the funds?
- Are the premiums remitted in cash?
- Can the agent use the premiums to pay claims?
- Is the commission deducted from the premiums?
- What information does the insurer require as support for each premium payment?
- Where is that information kept?
- In the absence of national identification numbers, how does the insurer wish to designate the insured?
- Does the policy come into effect when the agent collects the premium payment?

The exchange of policyholder information relating to premium payments must also be carefully assessed. What information is really needed by the insurer relating to premium payments? AIG Uganda, for example, requires MFIs to pay aggregate premiums on a monthly basis – which is efficient – but the payment must be accompanied by a physical list of all those covered under the group policy. One MFI submitted close to a ream of paper each month to satisfy this requirement. This process requires significant effort, supplies and even storage space. It is clearly not efficient.

Alternatively, Aldagi in Georgia, with its MFI agent Constanta Foundation, uses an electronic system that downloads relevant data automatically on a daily basis. There is virtually no human intervention in this process. Other MFIs with savings capabilities, like K-Rep Bank in Kenya and the rural banks of Ghana, require the insurer to retain the premiums in an account in their banks. This simple arrangement assists the microfinance banks with liquidity management.

Any partner-agent agreement should ensure that as much as possible is done electronically. The use of computers and electronic communications is an important way to reduce the cost and effort of managing microinsurance, as well as of collecting the necessary client demographic data.

Claims processing

Since timely claims payment is critical to the credibility of the institutions (not to mention to the needs of the beneficiaries), an agreement on **service standards** is imperative. In some of the early experiences with the partner-agent model, insurers generally insisted that they pay claims, but often with very poor results. In ASA's experiences with Life Insurance Corporation of India (LIC), claims regularly took three months or more to be paid, and even then a number were rejected because they were unable to prove the age of the deceased (some were never issued with a birth certificate) or because some of the required documentation used a nickname rather than the official name. Some microinsurers had a backlog of claims, with some stretching beyond a year. This is unacceptable for any microinsurance programme.

To avoid these problems, many MFIs such as ASA and Kashf in Pakistan decided to settle claims directly. This can be a sensitive issue for insurers, but where it is done, beneficiaries profit from the practice. Common among the affiliates of Opportunity International, Leftley (2005) refers to this approach as an amended agency agreement. The MFI verifies that the claim is valid and, if so, pays the claim from the premiums collected but not yet submitted to the insurer. At the end of the month, the MFI submits the net premium schedule showing the total premium collected and the total claims paid, along with all claims documentation. In the event that the insurer identifies a claim that was paid in error, then the MFI is responsible for refunding the insurance company. This issue is further described in Chapter 4.5.

If the insurer insists on paying the claims, an innovative alternative has been a settlement guarantee, whereby the insurer agrees that claims (with proper documentation presented) will be settled within two weeks or it will pay a bonus of, for example, 25 per cent. This reduces the liability of the MFI and creates an incentive for the insurer to perform efficiently. Clearly, the extra step of getting documents to the insurer for payment back through the MFI is time-consuming, and those that pay directly have an advantage with their clients as long as controls are simple, clear and effective.

While it may be possible for the MFI to pay claims for life insurance, it is more difficult for other types of cover. Even making the distinction between natural and accidental death may be difficult for the MFI's field staff. Health insurance is even more complicated. Among a variety of other controls, VimoSEWA (India) and UMSGF (Guinea) employ doctors to participate in claims committees to assess whether clinics are providing the correct treatment and following approved protocols. Generally, health insurance claims are too onerous for agents to manage.

With a different approach to claims verification, United India Insurance Company (UIIC) worked with Shepherd, a microfinance NGO, to create a review committee to address microinsurance implementation issues and decide upon questionable claims. This committee is composed of two representatives from UIIC, two from the policyholders, and one from Shepherd. The committee permits effective responses to claims issues and supervision of product implementation, as well as enhancing the overall control of the programme.

2.4

Implementation

As with other aspects of microinsurance delivery, efficiency in implementation is critical –and this is where a partner-agent relationship can prove its worth. In principle, the MFI's staff frequently interact with their clients. The opportunities to cross-sell insurance are thus frequent and the incremental cost of this should be almost negligible. The idea is to use existing networks and relations of an MFI agent to add another product, which theoretically should lower acquisition and transaction costs, especially when compared to using specialized insurance agents to sell individual products.

Yet the theory of implementation has not matched the reality of dealing with MFIs. The simple cross-selling approach has not been successful in many institutions, primarily because microinsurance is not the agents' core business. Typically, savings and credit are the core business of an MFI. Insurance may support the core business, for example by mitigating the credit risk of the agent as well as its clients, but when delinquency problems arise, there is little effort to market insurance. As the loan portfolio is the key asset and income generator for most MFIs, it is logical that when it is threatened, the attention of management and staff will shift to address this problem. This point is true of other delivery channels also and illustrates an important hurdle for advancing microinsurance. Offering microinsurance efficiently through other organizations will always result in second class treatment for such products compared to the delivery channel's core business.

Even when things are going well, some potential microinsurance agents have no interest in insurance because core business growth takes up all available resources. ProCredit Bank in the Ukraine, for example, was marginally interested in microinsurance and began testing a partnership with a local insurance company. Before the test was even concluded, it became clear that, due to phenomenal growth in its core business, management would not divert its attention to a non-core product.

The expectation that microinsurance could be seamlessly implemented into an MFI with essentially no additional cost has proved overly optimistic. Several institutions have recognized the need to have someone within the agent institution to liaise between the insurer and the MFI. In some cases, the agent allocates someone to manage the relationship from its side, to oversee training, manage the reporting and communications with the insurers, answer questions from staff and generally act as the insurance product manager. In some cases, as with GLICO, the insurer will actually place one of its agents with the MFI to ensure proper sales and service.

The expectation that an MFI's staff will cross-sell insurance has generally not been satisfied either. Demand and customer satisfaction studies have shown that microfinance clients often have little understanding of the insurance products they have purchased. This is especially true of mandatory products. When a product is mandatory, field staff see little reason to promote or even discuss the microinsurance product.

Commitment to keeping clients knowledgeable and informed is necessary for success in microinsurance. Without such a commitment, policyholders only see insurance as an additional cost to borrowing for mandatory products and voluntary products are likely to experience low renewal rates.

2.5 Financial arrangements with the agent

Although MFI agents have generally limited their microinsurance offerings to products that directly relate to their loan portfolio protection needs, they also rightly expect a direct financial benefit from selling insurance for an insurer. Three remuneration methods were identified in the case studies:

1. Commissions paid to the agent as a percentage of the premiums collected
2. Profit sharing with variable income/loss potential
3. Premium mark-ups where the MFI agent adds an additional amount to the premium charged by the insurer

Commission-based remuneration

The most common way for MFI agents to earn income from insurance is through commissions, which typically range from 5 to 20 per cent of premiums paid. Some of the more professional MFI agents track the costs of selling and servicing microinsurance products. It is critical for the agent to understand its insurance-related cost structure and to ascertain if it is at least breaking even on the activity. Some MFI managers argue that, because the activities are added to the existing infrastructure and delivered concurrently with credit or savings products, insurance effectively generates no additional cost.

However, without a costing analysis, agents are never sure of the product's profitability.

Using activity-based costing (ABC), ASA assessed the cost associated with the sales and service of its insurance products and determined that the administrative cost per policy per annum is US\$1.80 (see Table 38).

Table 38 ASA's cost per policy (January 2005)

Category	Annual expense (Rs.)	Annual expense (US\$)
Staff costs	1 500 000	33 333
Non-staff costs (e.g. stationery, rent, computers)	1 460 000	32 445
Branch incentive fee	1 325 250	29 450
Total annual costs for all policies	4 285 250	95 228
Total number of policies sold	53 010	
Total servicing cost per member	80.84	1.80

Source: Roth et al., 2005.

Table 39 assesses the profitability of its microinsurance activities on the basis of the cost per policy. The premium per policy is consistent at Rs.125 (US\$2.78), but the premium retained is different for Max New York. When the cost per policy is compared to the premium retained per policy (column B), it is clear that there is a profit with the first two insurers and a loss with the third.

When this costing was carried out, ASA's administrative costs were 64.6 per cent of premiums and profits were 4.8 per cent of premiums.⁴ (Additional administrative costs must also be applied against the balance that was paid to the insurer.) By tracking costs and incomes in this way, an agent is better able to manage the level of costs, and in this case it is clear that there is a need to identify potential additional efficiencies to reduce the very high administrative costs.

⁴ The weighted average cost per policy is Rs. 86.8, or 69.4 per cent of premium. Administrative cost to premiums is $80.84/125 = 64.6$ per cent, and profit is $(86.8-80.84)/125 = 4.8$ per cent.

Table 39 ASA's profit/loss per policy (January 2005)

<i>Insurance company</i>	<i>A) Premium received from the client</i>	<i>B) Premium retained to cover expenses</i>	<i>C) Profit or loss per policy (Column B-Rs. 80.84)</i>	<i>D) No. of policies</i>	<i>E) Profit or loss on all policies (Rs.)</i>	<i>F) Profit or loss on all policies (US\$)</i>
AMP-Sanmar	125	89	8.16	26 444	215 822	4 796
Allianz Bajaj	125	89	8.16	18 218	148 686	3 304
Max New York	125	75	-5.84	8 348	-48 740	-1 083
Totals				53 010	315 768	7 017

Source: Roth et al., 2005.

Table 40 Performance of four microinsurance schemes in Zambia

	2004			
	<i>Pulse Holdings</i>	<i>PRIDE Zambia</i>	<i>FINCA Zambia</i>	<i>CETZAM</i>
Premium value (US\$)	25 345	28 098	31 826	17 507
Claims (US\$)	12 252	5 034	3 302	1 613
Claims ratio (%)	48.3	17.9	10.4	9.2
Net premiums (US\$)	13 092	23 063	28 534	15 894
Profit sharing (US\$)	4 582			
Profit sharing (%)	18.0			
Admin fee (10%)		2 810	3 184	1 751
	2003			
Premium value (US\$)	18 603	4 010	9 571	7 544
Claims (US\$)	9 803	786	976	3 749
Claims ratio (%)	52.7	19.6	10.2	49.7
Net premiums (US\$)	8 800	3 224	8 595	3 794
Profit sharing (US\$)	3 080			
Profit sharing (%)	16.6			
Admin fee (10%)		401	957	754

Source: Manje, 2005.

Profit-sharing

The second remuneration approach, profit-sharing, is a means of sharing the risks and profits to generate a potentially greater income (or loss) for the MFI agent. This method places some of the risk of insurance with the institutional agent. Typically, this potential liability is capped at the amount of premiums paid, so the MFI agent might possibly lose its investment in the costs of selling and servicing the products, but any additional loss is borne by the insurer.

Madison Insurance works with four institutional agents in Zambia. Three are paid a guaranteed commission of 10 per cent of premiums, while the fourth, Pulse Holdings, is paid on a profit- (and risk-) sharing basis. Table 40 shows some key results from the four MFIs.

In this case, the profit-sharing arrangement calls for Madison to pay the claims from the premium pool and then retain 35 per cent of the net premiums (after claims) to cover its costs. Any balance is then shared equally between the insurer and the MFI. This arrangement provided a greater return for Pulse Holdings over the two years – 16.6 per cent for 2003 and 18 per cent for 2004 – than the guaranteed 10 per cent return for the others, even though Pulse had a dramatically higher claims ratio. It is important to recognize that with a profit- and risk-sharing mechanism, the return could be zero. However, it appears that Pulse, and Madison itself, are protected by excessively high premiums. The claims ratio for Pulse in 2005, for example, would have had to be over 70 per cent for Pulse to make only the 10 per cent that the others earned. With the average aggregate claims ratio for the commission-based agents at only 16 per cent, it is clear that this product is seriously over-priced.⁵

Premium mark-ups

The third option is premium mark-ups, such as those used by many MFIs in Uganda which impose a surcharge of up to 100 per cent on the premium. In other words, if the insurance cover costs 0.5 per cent of the loan amount, the MFI charges 1 per cent and keeps the other 0.5 per cent. In the case of AIG Uganda, the insurer does not pay any commission to the MFIs, but it does pay a 20 per cent commission to its own insurance agent. This results in an unconscionable level of administrative costs and premium levels, which are multiples of what would be reasonable. Additionally, it is likely that such mark-ups are illegal in countries where the insurance authorities officially approve premiums.

⁵ Note that with an aggregate claims ratio of 16 per cent plus the 10 per cent administration fee paid to the MFIs, Madison has 74 per cent of premiums to split between 1) the very low administrative costs of its operations related to these products, 2) probably no reinsurance costs and 3) profits which are likely to be between 50 per cent and 60 per cent of premiums.

In the Philippines, Opportunity International steered its MFI affiliates towards this mark-up approach after it learned that it was common practice to increase the premium rate significantly if a commission is paid to the intermediary. For example, if a 20 per cent commission is required to cover the MFI's costs, then it is common for the net rate without commission to be increased by over 100 per cent. On the basis of this observation, it was agreed that MFIs would pay the net rate to the insurer and receive no commission, but would instead load the rate charged to the clients with an administration fee. This resulted in a cheaper end-solution for the organizations' clients.

2.6 Conclusion

In implementing the partner-agent model, there are several areas of concern that should be worked out before the product is offered to potential policyholders. Each party must understand its role, and the roles should be allocated on the basis of where each institution's comparative advantage lies. In developing the product and negotiating with the insurer, the MFI agent has a dual role: it must ensure that its own institutional requirements are met in terms of distribution, cost cover, and capacity requirements, but it must at the same time represent its clients and their needs. In some cases, especially in Asia, MFIs have done commendable work in representing their clients' needs and negotiating products that respond to those needs. In most cases however, MFIs appear too focused on their portfolios and on generating significant earnings, resulting in products that neither reflect their clients' needs, nor offer them real value.

3 The good and the bad

The partner-agent model has not been for everyone. Many find that it fits their needs. Some, like VimaSEWA and ASA, began with the partner-agent model, moved to self-insurance, and then back to the partner-agent model. As described in Box 71, ASA is finally firmly committed to the partner-agent model now that it is better able to manage the relationship with insurers and can influence the design of the products.

Box 71

ASA's on-again off-again on-again relationship with the partner-agent model

ASA has flip-flopped between the partner-agent and full service models several times over the years, sometimes even combining the two (e.g. carrying the risk of natural death in-house, but outsourcing accidental death cover to an insurer). However, it now appears firmly committed to collaborating with

insurance companies. Part of this commitment is due to its experience; it recognizes the risks of in-house insurance without reinsurance. Another factor is that ASA has had sufficient experience with insurance partners for it to know now what to ask for and how to manage the relationship – and with 45,000 borrowers, it has the volumes to be demanding. As a result, ASA has designed its own product to meet its needs and generate a little income, while someone else takes the risk.

Source: Adapted from Roth et al., 2005.

Insurers working with MFI agents have experienced mixed success with this model. Penetration has been relatively low with voluntary products, although some agents are more successful in distributing insurance than others. Some of the factors correlated with sales success include:

- **The size of agent’s client base** – Agents with more clients tend to experience better penetration rates than smaller ones.
- **Management attitudes** – Agents that are more successful appreciate the strategic nature of insurance in their product offering and demonstrate appropriate management disciplines such as setting sales targets.
- **Employee attitudes** – The attitude of the field staff to insurance is a critical factor in achieving positive sales results. If they are not enthusiastic about the product, it is difficult to achieve sales success.

Although insurers typically want to “offer” **compulsory insurance**, this only makes sense when there is a direct relationship between the product and its compulsory nature. For example, an MFI can link credit life cover to a working capital loan or home insurance to a housing loan. When insurers offer products that reach beyond the direct link, they must be voluntary, and therefore must be actively sold by the intermediary. This has proved difficult.

As it is currently conceived, this model is limited to the depositors or more probably the borrowers of an MFI. Yet there are few places where microfinance institutions work with even 10 per cent of the potential market. In a country like India, where insurance regulations require insurers to serve the low-income market, Tata-AIG found the partner-agent model too restrictive. Too many microfinance institutions already had relationships with other insurers, and the penetration of MFIs in India was low compared to the potential market. Thus, Tata-AIG developed its own model using NGOs to identify local people to become “micro-agents” (see *Chapter 4.6*). The saturation of MFIs willing and able to work with insurers in India coupled with the relatively limited outreach of MFIs is an important considera-

tion for the partner-agent model, and will continue to push insurers into identifying and working with non-MFI delivery channels.

Delta Life experienced similar challenges when it tried to offer insurance through a microfinance NGO in Bangladesh. Part of the problem lies with the type of product that Delta and Tata-AIG offer. Microfinance institutions are not particularly effective distributors of **endowment policies** for two reasons. MFIs typically tie their policies to loan products. Endowments require long-term, consistent transactions. MFI credit is usually short-term with occasional non-borrowing gaps. There is limited compatibility between these two approaches. Also, for MFIs that accept savings, endowment products compete for the limited resources of the low-income client.

Chapter 1.2 describes the demand for microinsurance from the low-income market and shows that in most countries the greatest need for risk-management assistance, and indeed the greatest need for insurance, is in the area of health cover. Initially, it was thought by some that **health insurance** would come as part of an evolutionary process. If insurers could be enticed into entering the market for life and other basic products, they could be gradually encouraged to move to more complicated ones, including health. Except for a few notable cases – such as VimoSEWA and Shepherd, both in India – this evolution has not taken place. The reason for this is both a general reluctance by the insurers and a lack of pressure for evolution by the MFI agents, who are also supposed to represent their clients. Since health insurance cannot be provided as a mandatory product in most places and the products do not relate directly to repayment of loans, this has hindered development of health cover through this model.

4 Advantages and disadvantages

In the partner-agent model, there are three key actors – insurers, MFIs or similar agents, and the low-income people ultimately covered by these policies. Although billed as a win-win-win approach, in practice the model has shown advantages and disadvantages for each of these groups.

4.1 The agents

For MFIs, it is easier to offer insurance in partnership with a formal insurer than to start their own insurance company or to insure on their own (*as shown in Table 41*). The ability to offer insurance without the requirements of knowledge, funds or regulations makes this an easy option.

The disadvantages generally relate to relationship issues. MFIs and insurers enter into negotiations with vastly different knowledge bases. The insurer knows insurance while the MFI knows the market. What makes this an ideal relationship – the merger of two skill sets – also creates the potential for abuse. Although both insurance knowledge and market access are key inputs, too frequently MFIs defer to the insurer’s expertise while failing to convey their market knowledge to the insurer. This is a mistake. Where MFIs are able to influence product design, or where there is insurer competition, there are clearly better products for clients at better terms.

Table 41

Advantages and disadvantages to the agent compared to self-insuring

<i>Advantages</i>	<i>Disadvantages</i>
1. Often the simplest, cheapest and quickest way to start offering insurance	1. Need to negotiate with a third party for a product that meets clients’ and the MFI’s needs
2. Lower financial and reputation risk	2. Income often restricted to commissions; low risk, but also relatively low reward
3. Guaranteed income from commissions, or potential income/loss from profit-sharing	3. Service standards may be in the hands of a third party (if the insurer is paying claims)
4. No capital requirements	4. Field staff have additional, non-core business responsibilities
5. Few or no regulatory requirements	5. Need to create an incentive structure to motivate staff to sell the product or at least keep clients knowledgeable about the products
6. No need for expensive specialist managers and staff	6. Potential limitations on product design and benefits due to restrictions on what the insurer will, or legally can, cover
7. Can offer products that are safer for clients	

For the partner-agent model to work for MFIs, a number of requirements must be satisfied:

- MFIs must use the size of their market to get what they want in products and terms. They must press insurers to offer products that respond better to the needs and demands of their clients, and push for continued product evolution to respond better to advanced client needs.
- There must be competition among insurers in the form either of a number of insurers selling to the MFI or of tender offers and annual policy reviews.
- There must be better integration of microinsurance in the front office, so that field staff appreciate the value of insurance to their clients and receive incentives to sell voluntary products and inform clients about mandatory products.

- The value of a range of insurance products for the MFI's clients, and indirectly for the MFI must be recognized. This will provide an incentive for MFIs to compel insurers to offer the products and to sell them in a professional manner to their clients.

4.2 The insurers

The advantages of this model for insurers are easy to identify. The disadvantages are relationship-based, as shown in Table 42. MFIs generally have made disappointing agents. They have been weak at marketing and the potential of the market they provide access to is rarely achieved with the insurance products offered.

Table 42

Advantages and disadvantages for an insurer

<i>Advantages</i>	<i>Disadvantages</i>
1. Simplest, cheapest and quickest way to enter the low-income market; the agent gives the insurer instant credibility with a sceptical market, large volumes of clients and an efficient transaction mechanism	1. Working with agents with limited knowledge of insurance
2. Improves risk diversification by adding substantial numbers of policyholders, especially with a mandatory product	2. Significant upfront effort in training MFI staff, and developing processes and marketing materials
3. Positive impact on corporate social responsibility requirements and relations with regulators	3. Reliant on the agent who could change its view of the insurer's products or services after the initial investment
4. Improved understanding of risks through agents' historical data on clients	4. Risk of losing a substantial portion of business should the agent shift to another insurer, or shift priorities
5. The product prototype should be developed from market research conducted by the agent	5. Service standards are in the hands of the agent leading to potential reputation risk
	6. Must adapt controls to manage special products

For the partner-agent model to work for insurers, they must:

- Take an active role in training and motivating the frontline agent staff (in coordination with the institutional agent). Some insurers have staff responsible for these accounts and their interactions must improve to make the agent's staff more effective.
- Recognize that insurance will never be the primary focus of any institutional agent and thus focus on making each process simple to offer, simple to manage, and simple to transact. If the product is simple in every way, the effort

required by the agent will be reduced, and there is greater potential for sales to be improved.

- Make sure policyholders are receiving correct information. This will improve the potential for renewals.
- Although the theory is that there would be limited intervention on the part of the insurer, it is clear from these case studies that insurers must have a stronger role in guiding the process.

4.3

The clients

Potential policyholders are at the mercy of their agents and the insurers. Access to regulated insurance products should be beneficial, but in many cases has not only proved unhelpful, but actually detrimental, at least in terms of paying unnecessarily high premiums for unsatisfactory products. This may have been justified initially as insurers took a conservative approach while they tried to understand the risk in this market. As significant data is now available, premiums should be falling, but they are not. Much of the problem relates to policyholders' reliance on two entities to represent them – the institutional agent and insurers, both motivated by profit. Advantages and disadvantages of the partner-agent model for the low-income market are summarized in Table 43.

Table 43

Advantages and disadvantages for low-income policyholders

<i>Advantages</i>	<i>Disadvantages</i>
<ol style="list-style-type: none"> 1. Gain access to products through regulated insurers that they would not have had otherwise 2. They should be able to take advantage of pool pricing 3. The insurer is backed up by reserves, legislation, and when appropriate, reinsurance so there should be virtually no risk of insurer failure 4. Have the potential to access a broad range of products 	<ol style="list-style-type: none"> 1. Their representative (frequently the MFI agent) has a conflicting role in negotiations, representing both its own objectives of profit maximization and those of value for money for its clients; often products are designed for the benefit of the agent 2. When there is conflict, clients are reluctant to confront their lender for fear that this may adversely affect their borrowing capacity 3. Too frequently low-income people can only obtain insurance if they are borrowing, and borrowing is not always necessary for the client 4. Premiums in most cases remain too high, as illustrated by the minimal level of claims to premiums observed in many programmes

For the partner-agent model to work for the low-income market:

- their clients' needs and demands must be the basis for products and how they are offered;
- regulators must allow simplicity in policies and procedures while protecting the rights of this market;
- MFIs must develop ways to include clients in their product development and review procedures, and then apply the information in their negotiations.

5 Conclusions

The partner-agent approach is still evolving. Over the last several years, insurers have become more interested in the low-income market; MFIs and similar agents have become more adept at structuring deals that best match their needs, and sometimes even the needs of their clients. There is still reluctance from insurers to offer health products, though this is changing. The initial reluctance to provide even life insurance has diminished to the point where insurers are seeking MFIs and other partners through which to access the low-income market. MFIs have a limited share of the low-income financial markets around the world. Now that insurers see the potential of microinsurance, they are actively searching for alternative and complementary delivery channels (*see Chapter 4.6*). It is clear from these cases that massive outreach will require new and efficient delivery channels.

On an institutional level, it was expected that premiums would initially be high, but that after a year or two of experience, the rates would fall and product ranges would expand. There should also have been a corresponding reduction in the net earnings of the insurers. Indeed, this has occurred with some of the insurers, though others are earning excessive returns. The controls on these profits must come from the MFIs and others that sell products to low-income clients.

There is market pressure to manage these premiums in ways that benefit the clients. AIG Uganda, which had a monopoly in this market until recently, has found itself struggling against two new competitors. This is the market in action. Competition in microinsurance will lead to better products and more appropriate premiums for low-income consumers. The forerunners of this model may not have had, and may still not have, products or premiums that truly respond to the needs and demands of this market. However, they have blazed a trail, and the newcomers will generate competition to improve insurance for the poor.

The partner-agent model currently seems to work best when:

- insurance is directly related to the products of the agent institution;
- the MFI agent has sufficient knowledge and motivation to actually represent its clients in negotiations with insurers and manage the product development process;
- the MFI agent recognizes the benefit of insurance not only in protecting the MFI's portfolio, but more importantly for its clients;
- products are simple in all respects, from the initial entry requirements to a policy with a minimum of exclusions, and a settlement process that makes it easy to submit valid claims;
- the products are valued by the MFI's clients, and are mandatory;
- premiums are fair for all concerned;
- the agent's field staff are sufficiently skilled and actually take the time to explain insurance and the product clients are buying;
- for the low-income market, the insurer develops a different business model from that used for its traditional clientele.

The partner-agent model has significant potential. It is still early in its evolution, progressing slowly on the basis of lessons learned. The flaws in the model can be addressed relatively easily through training and capacity-building of both the risk carriers and delivery channels. However, insurers would be wise not to put all their eggs in the MFI basket. These case studies have shown that massive expansion of microinsurance will require a broad range of delivery channels and that working with MFIs alone will not be sufficient.

4.3

The community-based model: Mutual health organizations in Africa

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This chapter deals with a specific microinsurance model, the community-based model, in a specific region, Africa. It also deals with a specific field – health insurance – which is certainly not the easiest type of insurance to offer (see *Chapter 2.1*). Considering that access to healthcare remains a major unresolved issue in Africa, health microinsurance systems are one of the ways to solve this problem, at least partially.

Community-based health insurance is not a theoretical model. It has been a pioneering approach to extending social protection since its development began more than 15 years ago. Based on several studies² and on the experience of external support organizations active in this field (particularly the ILO's STEP programme and the French NGO CIDR), this chapter explains past and current developments in this specific model.

This chapter is divided into six sections. The first section describes a specific community-based model, the mutual health organization (MHO) and its theoretical application in West Africa. The second section provides information on the proliferation of this model in West Africa while few other approaches have been tested in the region. Section 3 briefly examines the target group of MHOs in West Africa. The next section explores strategic questions, namely: do the mutual health organizations function (well) and are they having an impact? To explain some observations made in this fourth section, section 5 examines the specific origins of the problems described. Finally, the last section illustrates the intrinsic added value of the community-based model.

¹ The references to Alliance Santé in Benin are drawn from the authors' experiences, not from the case studies.

² For example, see Atim, 1998, Atim et al., 2005, Fonteneau, 2004, Fonteneau et al., 2004, Jütting, 2002 and Tabor, 2005.

I What is a community-based model?

It is difficult to give a standard definition of community-based microinsurance. Literature on the subject has almost as many definitions of the model as there are community-based organizations (CBOs) or specialists. In practice, various insurance schemes containing some community-based elements have been experimented with throughout the world. Uganda has tried several systems governed and managed by hospitals involving community groups in the design of benefit packages and collection of premiums (Dierrennic et al., 2005). Tanzania is implementing a nationwide system called the Community Health Fund (CHF). Members are organized in management committees, which include the healthcare managers, although the rules of the CHF (including the premium amount) are fixed by district authorities (Musau, 1999). Another way of managing health microinsurance is through MFIs. If an MFI is community based, which is to say organized as a mutual like AssEF in Benin, its microinsurance scheme could be included in the community-based model.

A few NGOs have experimented with health microinsurance managed by professionals, which shares the objectives and features of a community-based model. For example, in the SKY programme launched by the French NGO GRET in Cambodia, professionals employed by the NGO manage the scheme. Clients in village committees are regularly consulted to ensure that the scheme is accountable to the policyholders (CIDR, 2005).

Notwithstanding this variety of community-based insurance schemes, this chapter focuses on one particular type: the mutual health organization or *mutuelle de santé*. The main geographical reference is West Africa because this model is most common in this region (Tabor, 2005).³

Mutual health organizations were originally developed in Europe in the 19th century where workers' organizations set up mutual funds to improve access to healthcare in the absence of other kinds of social protection. In several countries, these initiatives have contributed significantly to the implementation of a social protection policy at the national level.

I.1 Essential features

The essential features of MHOs demonstrate their strong community-based nature and reflect the purposes and operations of the model:

³ Some examples provided by CIDR come from other African countries since CIDR is one of the only external support organizations implementing MHOs elsewhere on the continent.

- Improve access to healthcare through risk-sharing and resource-pooling
- Not-for-profit
- Mutual-interest organizations based on groups sharing common characteristics
- Members are owners and beneficiaries at the same time
- Participatory decision-making
- Voluntary membership
- Promotion of solidarity, democracy and social cohesion
- Potential functions beyond insurance

Like other insurance systems, mutual health organizations are based on a mechanism of risk-sharing and resource-pooling. However, more specifically, these organizations are non-profit and do not select their members on the basis of their individual risk profiles. Access to healthcare through solidarity is thus the main objective of these organizations.

The members of mutual health organizations are the owners, the decision-makers and the policyholders, which strongly differentiates this model from other insurance schemes. This feature requires strong participation and control mechanisms to make collective decision-making effective. Annual general meetings decide on issues such as budgets, accounts, what to do with surpluses, and operational matters as well as overall strategy. Members govern their MHOs through elected representatives, who are responsible for implementing control mechanisms, such as monitoring the implementation of internal rules, controlling financial flows and collecting complaints relating to the service provided.

Membership is voluntary. This principle clearly distinguishes MHOs from compulsory insurance schemes such as most national and often state-run social security systems. As in any non-profit organization, a person may choose to become a member but is never forced to join.

In most MHOs, members share some common characteristics, such as being members of the same organizations, inhabitants of the same village or workers in the same trade, often because they are built on an existing organization (*see Box 72*). Bearing in mind that membership is voluntary, an MHO has to find a way of ensuring that it can gather a “sufficient” number of members to run the risk-sharing mechanisms in an efficient and attractive way: the larger the group, the greater the benefits for the members. Being organized in a (formal or informal) pre-existing group facilitates this process. In addition, sharing some characteristics, or better, being previously involved in similar collective decision-making mechanisms with the same group, facilitates the functioning of an MHO.

Box 72

Profiles of initiating organizations of MHOs

In Burkina Faso, the Association *Yekouma Dakoupa* and the Association of Widows and Orphans from the Leere (*Association des Veuves et Orphelins du Leere*) offer a range of services such as agricultural support, microcredit and school fees for orphan children. A group of women organized an informal solidarity fund to help members and their families when facing a health event. Worried that this fund would not be sufficient to cover all needs and health expenses, they decided to set up a more sustainable system. They contacted the STEP programme with whom they set up a mutual health organization called Leere Laafi Bolem in 2001.

In the case of the *Lalane Diassap* MHO in Senegal, a village youths' organization (*Association des Jeunes de Lalane*) took the initiative to launch a village-based mutual health organization in the mid-nineties. Staff already working with other mutual health organizations in the Thiès Region helped to launch this initiative.

In the case of the *Mutuelle de Fatako* (Guinea Conakry), a women's association (*Association des Femmes Ressortissantes de Fatako*) identified access to healthcare as a major problem for Fatako inhabitants. Together with the STEP Programme and the *Association Guinéenne de Bien-Etre Familial* (ASBEF), they created a mutual health organization in 2002.

Source: Adapted from Fonteneau et al., 2004 and Fonteneau, 2004.

MHOs actively promote some ideals like solidarity, democracy or social cohesion. These values are particularly important for the resource-pooling and risk-sharing of microinsurance, since members' familiarity with each other can assist in controlling moral hazard and fraud, and can encourage renewals.

However, unlike other insurance providers, an MHO cannot be reduced to its insurance function. As participatory, mutual-interest organizations, MHOs fulfil functions beyond insurance. For instance, the MHOs objectives almost always include health education. They also act in a sector (healthcare) where the interests of users have only recently been represented. By organizing potential users of health services, MHOs can represent their interests to healthcare providers. In the same way, since the state is a key actor in healthcare systems, MHOs can represent the population in policy discussions. For example, these community-based organizations may lobby on health financing issues and participate in social protection reform processes (see Chapter 1.3).

1.2 Consequential features

Apart from these essential features, other characteristics are also worth mentioning to provide a more complete picture of the MHO model. These features are “consequential” in the sense that they result from the model, but are not inherent characteristics.

The setting-up of an MHO often implies the creation of a new organization even when an existing organization takes the initiative to start a micro-insurance scheme. In other models, insurance can indeed be developed as a product offered and managed by an existing institution (e.g. MFIs or insurance companies). In the case of an MHO, the insurance scheme is the organization. The new organization created for the purpose of providing insurance leads to an institutionalization process that requires extra effort from the initiating organizations and/or from external support providers.

The MHO schemes are managed and controlled by members who financially contribute to them. This does not mean that an MHO has to be self-managed, but in reality this is often the case. Managers, who are members themselves, are elected or designated by the members of the insurance schemes. They often fulfil this function on a voluntary and unpaid basis. Voluntary “self-management” is one way to ensure continuity between the members and the institutions, and avoid conflicts between the management and the beneficiaries. However, voluntary, unpaid jobs are also chosen out of necessity due to the lack of resources. This practice reduces the costs of the insurance product, but is not a long-term solution.

As mentioned earlier, microinsurance schemes consist of members sharing some common characteristics. This feature ensures the necessary minimum level of trust and social cohesion to set up and run an MHO according to the features described (i.e. self-management, a collective decision-making process, participatory mechanisms, risk-sharing). Especially in the beginning, the membership of an MHO is often homogenous, which can have negative effects due to a lack of risk diversification. Such a situation also has a limited ability to achieve vertical solidarity, which allows for cross-subsidization between richer and poorer people.

2 Why was/is this approach implemented in West Africa?

The existence and implementation of MHOs in Africa did not occur by chance. African MHOs first appeared in the late 1980s and early 1990s, coinciding with two developments: 1) the democratization process and 2) the implementation of the Bamako Initiative.

In many African countries, the late 1980s represented the beginning of democratization and the emergence of a civil society. As a result, many initiatives were undertaken by the population to respond to urgent needs and political issues. These initiatives were encouraged by development cooperation agencies that wanted to support the democratization process. In this context, the associational affiliation of MHOs as non-profit, autonomous, mutual-interest organizations was an easy and flexible way to launch a collective initiative.

During the 1990s, the Bamako Initiative (launched in 1987 by the World Health Organization and UNICEF) was also progressively implemented. Designed to secure universal access to quality primary healthcare, the Bamako Initiative rests on three principles. First, primary healthcare services must attain a sufficient level of self-financing, which requires patients to contribute through user fees. The second is the principle of better access to medicines, particularly generic pharmaceuticals. The third principle is community participation to enhance the quality of care. If representatives from the local community sit on the boards of the healthcare centres, this will make the providers more transparent and responsive. This last principle recognizes that a range of actors should be involved in the healthcare system, including community-based organizations.

However, other regions have also been through a democratization process and have also gone from free healthcare to user fees. What explains the relative uniqueness of the insurance model implemented in West Africa? One explanation stems from the profile and background of the external support organizations involved, and more generally from the colonial history of the region. The development of MHOs is not a purely bottom-up phenomenon since external actors played a strategic role from the beginning. In Senegal and Burkina Faso, for example, the Catholic Church helped initiate some of the earliest *mutuelles* in the late 1980s.

The organizations currently involved in the development of microinsurance in West Africa have some common characteristics. Since the beginning, Belgian and French NGOs (e.g. CIDR and the Belgian NGO World Solidarity) have played an important role in the dissemination of the MHO model, which they considered an appropriate mechanism in an environment lacking in social protection; it was also a model for which they could offer unique know-how. Other external support organizations (e.g. Partnership for Health Reform, United States) followed this trend in West Africa. For similar reasons, French, German and Belgian development cooperation agencies were also active in this field.

Among international organizations, the International Labour Organization through its programme STEP (Strategies and Tools against Social Exclu-

sion and Poverty) engaged in the development of health microinsurance as a strategy for extending social protection to the unprotected population. The main target group of the ILO (workers), and the reference to certain social protection models and normative framework (social economy, not-for-profit sector), also explain the ILO's affinity for the MHO model.⁴

3 What is the target group of the community-based model?

Mutual health organizations are not defined by the profile of the target group and the model is not restricted to poor people (*Box 73*). This kind of organization, belonging to the third sector (the others being the state and the private for-profit sectors) can be adopted for normative reasons and/or because these organizations can provide some services more efficiently.

Box 73

A variety of membership profiles

The members of MHOs associated with the UTM (Mali) range from state employees to groups of informal women workers producing artisan soap. One could say that MHO members come from the entire range of population groups including formal and informal-sector employees, full and part-time workers, rural and urban dwellers, and women and men. In other words, the MHO movement penetrates every possible niche of Mali's society and is growing slowly, but steadily.

Source: Adapted from Fischer et al., 2006a.

The MHOs affiliated with UMSGF (Guinea) generally target people working in the informal economy and those who do not have access to health insurance through their employers. In rural areas, the place of residence defines target populations. Here farmers represent the majority of the village's working population. In urban settings, the majority of the members are artisans and traders. Retired persons, civil servants and other employees can become members as well since MHOs do not discriminate according to socio-economic or health criteria. Employed persons account for 10 to 20 per cent of the urban membership. The illiterate account for 57.6 per cent of membership. The median income is estimated at € 120 (US\$150) per person per year, or € 0.33 (US\$0.41) per day according to the preliminary study carried out in 2000.

Source: Adapted from Gautier et al., 2005.

⁴ Today, the ILO also supports other microinsurance models throughout the world.

A common characteristic of MHO members is that they do not have access to or are insufficiently covered by social security systems, and they could not afford the insurance premiums of for-profit insurance companies, if such services were indeed available (which is rare, especially in rural areas). In practice, most MHO members have variable and irregular incomes from their activities in the informal economy and/or agricultural sector. Nevertheless, MHOs may also cover state or formal sector employees. In West Africa, given the distribution of the population, MHOs are more present in rural settings than in urban areas (*see Box 74*).

Box 74

The target population of the rural MHOs

In rural areas, the target population of most MHOs supported or studied by CIDR in Western or Eastern Africa can be considered poor. However, within the target population, the economic status of households that do register with MHOs is not always known.

To evaluate the profile of the members of MHOs promoted by CIDR in Tanzania, a survey of 185 households was carried out in 2005. The result shows that average and median income of members is higher than non-members' income. The size of member households is smaller than that of non-member households, which suggests that large households have more difficulty paying the premiums.

	Level of income in €		Size of household	
	Average	Median	Average	Median
MHO members	1 061	713	7.4	6.0
Non-members	872	664	8.0	6.0

(€1 = US\$1.26)

Although the amount of the premium does not exceed US\$2.50 per individual and per year, these results clearly show that the less wealthy households are less represented in MHOs. The destitute are not the only ones who cannot join the schemes.

Source: Adapted from Dkhimi, 2005.

4

Do MHOs function (well) and make a significant impact?

The transition from theory to practice provides an opportunity to assess how well these schemes operate and whether they achieve their objectives. To give a fair answer, it is important to be aware of the information available on these issues and the perspective adopted in answering it. So far, most research has

focused on the organizational aspects of community-based schemes. As a result, there is information on the functioning of MHOs and the difficulties experienced in their set-up phases, management and social dynamics.

However, knowing how well they function is different from knowing how they perform according to a defined norm. For example, do MHOs only have to offer social protection to their members or should they actively contribute to the extension of social protection to excluded population? Is the primary objective of an MHO to improve access to healthcare or to improve financial security when households face health shocks? Is the insurance function of an MHO more or less important than the social participation and empowerment potential it makes possible? The answers will differ according to the perspective adopted: is it from the point of view of national organizations, mutual health organizations, external support agencies or national health authorities? In accordance with their autonomous identity, this chapter tries to answer this question in relation to the objectives and perspectives of MHOs.

The same problem arises for the second part of the question concerning their impact: against what criteria can performance be measured and are MHOs effective? In addition, is there enough solid data to address this question fairly? With a few exceptions, the answer is no, which will limit the possible analysis on the performance of mutual health organizations in West Africa.

4.1 Do MHOs function (well)?

In a study of 11 francophone African countries, 622 health microinsurance schemes were identified (Concertation, 2004). This estimation covered not only MHOs, but also a broader range of insurance models. Nevertheless, 88 per cent of the schemes defined themselves as *mutuelles de santé* (MHOs). Of the 622 health insurance schemes, 366 were functional (58.8 per cent). Most of the remainder had just been set up (22.8 per cent) or were in a pilot phase (12.4 per cent). The last 5 per cent were unable to cover their members' claims.

The functioning of MHOs has received a lot of attention from researchers and practitioners. Based on several studies, this section summarizes what has been reported in this area.

Most MHOs have a small membership. With a few exceptions, most cover less than 1,000 persons. Besides the voluntary nature of membership, there are other reasons for this limited penetration: the recent introduction of this mechanism, the limited capacity of the initiating organizations to provide technical assistance and the difficulty in reaching populations beyond

the members of the initiating organizations. In addition, many schemes encounter marketing problems as they strive to raise awareness and educate members. Considering that this function has to be constantly carried out, marketing problems constitute serious obstacles to the stability and growth of MHOs.

Management of MHOs is undertaken by unpaid volunteers, generally elected or designated by the members. A certain discontinuity of daily management occurs due to the voluntary nature of the work, as well as a lack of motivation and management skills. For the same reasons, participation mechanisms and collective decision-making organs do not in practice function as intended. The learning phase of these young organizations, the lack of human resources (leading to some concentration of power), and the continuous administrative work needed to run an insurance scheme could also explain the above observation regarding management. Nevertheless, these organizations show some positive trends towards institutional viability. They constantly try to adapt their management systems to make them more efficient, taking into account their limited resources. For instance, some MHOs decentralize their management system (or put external persons such as healthcare providers in charge) to bring the organizations closer to the members as well as to enlarge their target group.

As shown in Table 44, insurance premiums are often low. The target group frequently cannot afford more, due to its modest and variable income. These low premium levels are also due to the essential objective of MHOs, namely improving access to healthcare by providing insurance that is affordable to a majority of people. Finally, and especially in the early stages, MHOs charge low premiums to attract the target market, since they need to cover many people to make risk-pooling mechanisms effective. It has also been observed that members involved in making decisions about the premium level often prefer to start with small amounts to gain experience with the performance of insurance. When confidence in insurance increases, and an insurance culture begins to take root, willingness to pay might be expected to increase, though this assumption needs to be verified.

Table 44

A comparison of premiums and benefits for selected MHOs

	<i>Mutuelle Wer werlé (Thiès, Senegal)</i>	<i>Mutuelle de Sirarou (Sud Bourgou, Benin)</i>	<i>Mutuelle Leere Laafi Bolem, (Zabré, Burkina Faso)</i>	<i>Mutuelle Têkêyé (Boni, Burkina Faso)</i>
Insurance premium (beneficiary/year)	2,400 FCFA	Single: 2,000 FCFA 2-5 persons: 8,000 FCFA 6-10 persons: 16,000 FCFA 11-15 persons: 24,000 FCFA	2,400 FCFA	500 FCFA
Benefit packages and coverage rate	Primary and secondary healthcare (100%) except echography/scan, medicines and delivery (50%)	Primary and secondary healthcare (100%)	Primary and secondary healthcare (100%)	Primary healthcare (25%)

Source: Fonteneau et al., 2004 (data collected in 2003). €1 = 656 FCFA, US\$1 = 514 FCFA.

If premiums remain low, it is not surprising that benefit packages are also limited. The premiums mainly give access to primary and secondary levels of healthcare in the public facilities (since they are the most important providers in West Africa, especially in rural areas). In some cases, the lack of providers limits the choice of scheme design. In other cases, the premium levels simply do not allow coverage at private healthcare providers.

Even though the premiums are low, there are low premium collection rates as well as high drop-out rates. Combined with the small membership, these factors raise a number of questions relating to member satisfaction (benefit packages, procedures), distribution (premium collection systems) and financial accessibility (levels of income, level of premium, etc.).

To become viable in the face of these challenges, some MHOs join networks, unions or federations. At present, a few effective federations can be found in West Africa, including:

- *Union des Mutuelles de Santé de Dakar* (more than 30 MHOs)
- *Coordination Régionale des Mutuelles de Santé de Thiès* in Senegal (39 MHOs)
- *Union Technique de la Mutualité (UTM)* in Mali (32 MHOs)
- *Alliance Santé* in Benin (27 MHOs).
- *Union des Mutuelles de Santé de Guinée Forestière* (28 MHOs)

In some cases, the creation of a union was part of the initial project (e.g. the UTM in Mali (*Box 75*) and the MHOs in Benin supported by CIDR). This design implies more expensive and technically complicated interventions, but increases the likelihood of sustainability.

Box 75

Union Technique de la Mutualité Malienne

The UTM was created after the Mali Government called on the *Mutualité Française* and French Cooperation to help develop a network of MHOs targeting workers in the informal economy. The Government did so after observing that increasing the availability of basic health services did not result in a significant increase in demand for these services because the population faced difficulties in paying the user fees required under the Bamako Initiative.

The UTM was created in 1996 and became an apex structure providing support to new and existing MHOs. Today, 32 MHOs covering 40,000 beneficiaries are members of the UTM. The Union offers a range of activities as varied as supporting the development of new MHOs, performing feasibility studies, developing new products, monitoring MHOs, representing MHOs at government meetings, and ensuring that the legal and regulatory framework is supportive of MHO activities.

Each MHO designs its own benefit package. In addition, the UTM has launched a highly standardized product, managed at the apex level, which has attracted large segments of the urban population. This product is so competitive that some formal workers covered by the statutory state-sponsored health insurance plan choose to affiliate themselves to an MHO to have access to the plan. This standard plan dramatically simplifies management at the MHO level and allows for the exploitation of economies of scale.

Source: Adapted from Fischer et al., 2006a.

In other cases, like the two networks in Senegal (*Box 76*), the union was created after the member MHOs. In this bottom-up integration, efforts have to be made to create structural relations between MHOs with different organizational cultures and different membership profiles. In addition, management tools and monitoring systems often have to be harmonized to allow supervision and, if necessary, financial flows between MHOs.

Box 76

Coordination Régionale des Mutuelles de Santé de Thiès

The *Coordination Régionale des Mutuelles de Santé de Thiès* was created in the mid-nineties by some MHO leaders in the Thiès Region. The 39 member MHOs benefit from a range of services offered by the Coordination, for example supporting the development of new MHOs, training MHO leaders, conducting feasibility studies, facilitating contracts between health service providers and MHOs and offering health education programmes. In this bottom-up process, the level of integration is lower than in, for instance, the UTM case. The variety of MHO practices (e.g. in terms of design, functioning, benefit packages and risk management) makes integration much more difficult.

Sources: Adapted from Fischer et al, 2006b.

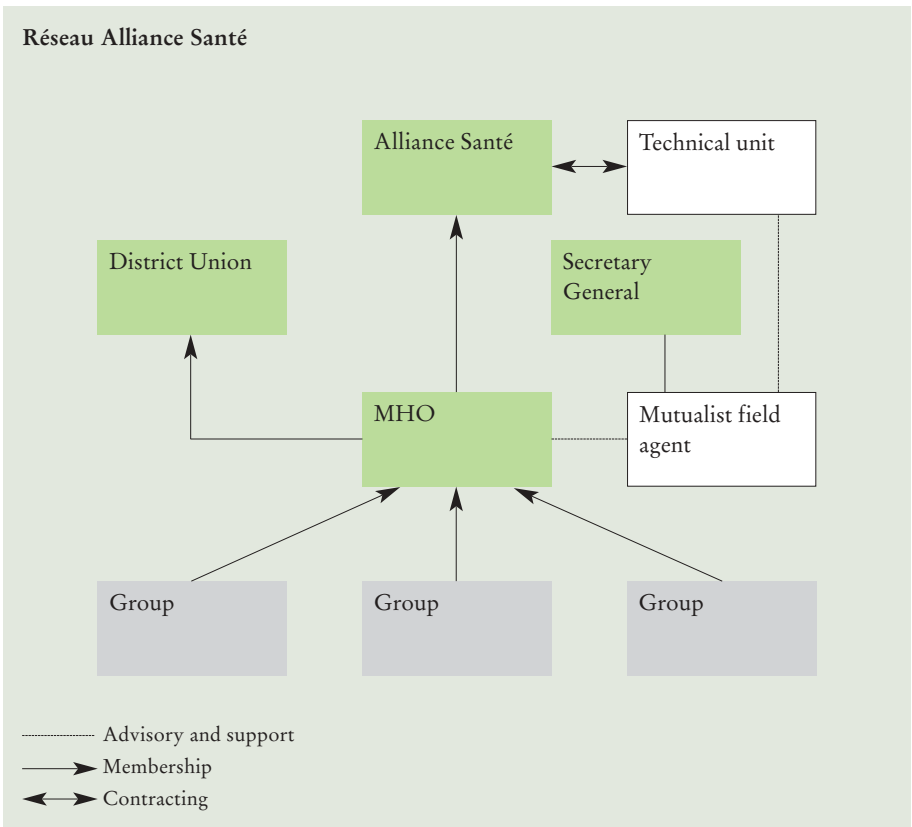
In either case, networks play three roles: a) political role (representation of interests); b) financial support role, for example through guarantee funds or reinsurance mechanisms, and c) a technical role through management support (see Box 77). Federations also represent a way to more “easily” integrate MHOs into a broader social protection system at regional or national level.

Box 77

Réseau Alliance Santé, Benin

Alliance Santé is an association of 25 MHOs representing 21,000 beneficiaries (in 2005). With assistance from CIDR, the association provides technical and financial support to the MHOs. Three mutualist agents employed by Alliance Santé help the MHOs’ board members with technical and financial management, claims processing and organizing their General Assembly. Alliance Santé is the owner of a guarantee fund, which lends money to selected MHOs when their reserves are exhausted, as well as a reinsurance fund to help MHOs to develop their activities. The MHOs pay for these services by allocating 10 per cent of their contributions to the Alliance.

The association also has a technical unit, staffed by a medical doctor and a risk management specialist, which is responsible for the specialized functions of microinsurance management, medical auditing, premium calculation and the design of new services. The technical unit is also in charge of the annual financial reports and external controls. An additional 10 per cent of the premium is allocated by MHOs to finance the technical unit.



The healthcare providers and, more generally, healthcare systems play a strategic role in the *raison d'être* of MHOs. If there is a lack of healthcare facilities, or if they do not offer minimal quality standards, there is no rationale to set up an insurance mechanism to improve access to non-existent or bad-quality healthcare. Even if healthcare providers exist, are financially and geographically accessible, and offer an acceptable level of care, the relationship between providers and MHOs can be problematic. These relationships represent a new factor for healthcare providers used to working as the sole stakeholder for all health-related matters in their districts (Wiegandt et al., 2002). The emergence of new actors in the health field that have other points of view and demand specific conditions can constitute a threat for the providers. In practice, healthcare providers can destabilize MHOs by not fulfilling what has been negotiated, through bad quality of care, unsatisfactory interpersonal relations, disruption in drugs provision and so on (Fonteneau et al., 2004; Criel et al., 2002).

4.2 Are MHOs making a significant impact?

The impact of MHOs could be evaluated through various indicators including a comparison of utilization rates and out-of-pocket expenditure between insured and non-insured persons. It is difficult to answer whether MHOs are achieving an impact, however, due to a lack of data, especially in comparison to control groups. Little information is available on the membership profile, determinants of affiliation and participation, or reasons for drop-out. Moreover, little is also known about the effect of membership: benefits of being insured (more visits when ill, lower out-of-pocket expenditure when visiting, etc.), and the social effects of being a member (better representation, improvement of quality of healthcare). Few systematic studies have been performed to assess the effect of MHOs on accessibility to healthcare services, health service cost recovery and levels of household health expenditure. When research has been conducted, it seems to show a positive impact (*see Box 78*), though a number of questions still need to be answered to understand the impact of these schemes.

Box 78

MHO performance: Some trends

Based on an action-research project in Guinea Conakry, Criel et al. (2002) demonstrated how a local MHO made a considerable impact on the utilization rate (new contact/person/year) of a healthcare centre.

	<i>Utilization by members</i>	<i>Utilization by non-members</i>	<i>Members/Non-members</i>
Primary curative consultations	1.8	0.5	3.6

CIDR also provides some interesting trends. For example, in Tanzania and Guinea, the inpatient ratio has doubled for MHO members. In Benin, the percentage of MHO women who deliver in a health facility is above 80 per cent, as compared to just 50 per cent in the overall total target population. In the MHOs in Comoros Island, Guinea, Tanzania and Benin, health providers agree that members are going to hospitals at an earlier stage.

If the level of satisfaction of MHO members is an indirect indicator of their effectiveness, then MHOs appear to be making an impact. Generally, the level of satisfaction for the services offered by these MHOs is high. Unfortunately, member satisfaction is constantly higher than the retention ratio would appear to indicate: many members who drop out are not dissatisfied with the scheme, but are simply experiencing financial constraints.

<i>Level of satisfaction with MHO services (%)</i>	<i>Very satisfied</i>	<i>Satisfied</i>	<i>Somewhat satisfied</i>	<i>Not satisfied</i>
UMSGF (Guinea)*	50.5	42.4	2.0	5.1
Self-managed Health Organization (Tanzania)**	56.8	20.0	10.6	10.6

* Satisfaction assessment CIDR survey 2004.

** Satisfaction assessment CIDR survey 2005.

5 What are the origins of the problems?

The previous sections give a rather negative impression of the performance and functioning of MHOs. Although interconnected, the problems discussed above do not all share the same origin. Some are more context-specific, others are related to the model itself, and finally some are related to external support.

5.1 Context-related problems

When MHOs began in the early 1990s, many were initiated by national NGOs or community-based organizations. Some problems, such as a lack of monitoring or technical skills, marketing and human resources, can be explained by the young, multi-purpose and inexperienced nature of the initiating organizations.

The limited healthcare supply, together with the low or poor quality of care offered by the public sector, was another context problem. The somewhat “closed” healthcare systems of these countries also meant that new actors like MHOs were not always welcome. Considering the internal problems of healthcare providers (financing mechanisms, lack of human resources and motivation of employees, etc.), the presence of MHOs – and even more, the presence of their external support organizations – led to expectations from the healthcare providers. If these expectations (training, financial incentives) were not delivered, healthcare providers might not act as “partners” of MHOs, but rather create obstacles to their functioning despite their official positive stance.

This micro-reality (goodwill of healthcare providers) must be combined with a more macro factor, namely the national political will to recognize and promote community-based insurance schemes. In recent years, several countries, including Benin, Senegal, Burkina Faso and Guinea, have included microinsurance schemes, and sometimes specifically *mutuelles de santé*, in their national health policies. In the same way, many West African Poverty Reduction Strategic Papers (PRSPs) also mention microinsurance as a poten-

tial tool for social protection or as a source of financing for the healthcare sector. However, these policies are not always translated into operational measures.

In West Africa, only Mali and Senegal⁵ have voted for a regulatory framework for MHOs (Senegal) in particular or *mutuelles* (Mali) in general. In some other countries, legislative preparatory work is under way.⁶ At the regional level, a project (*Appui à la construction d'un cadre régional de développement des mutuelles de santé dans les pays de l'UEMOA*) was launched by the West African Economic and Monetary Union, French Cooperation and ILO/STEP in 2004. Still, most MHOs operate under the national laws regulating associations or under the legal statute of their initiating organizations. Although this situation is not a major problem in the day-to-day management of the schemes (Fonteneau et al., 2004), MHOs and their support organizations are petitioning for an appropriate regulatory framework to take into account the specific characteristics of MHOs and to promote the creation of such organizations rather than to discourage it.

5.2 Model-related problems

Some of the problems identified are related to the specific community-based insurance model. However, one nuance has to be recognized. The model-related problems presented below cannot be disconnected from the West African context where this model has mainly been implemented. This means that the model, as such, may not automatically lead to the same consequences in other environments.

Until now, most MHOs have been run by unpaid volunteers on a self-management basis. Even if the model's essential characteristics entail the active involvement of members in the political and strategic decision-making, this does not mean that the managers have to be unpaid, and possibly unmotivated, members. Financial prudence (especially at the beginning) and scarce resources explain why this has happened. With a few exceptions, the instability and dissatisfaction of volunteers are now recognized as recurrent problems. Solutions can be found (e.g. external funding, effective use of premiums), but are not always sufficient.

All participation-based or collective-action stories demonstrate that these processes take longer than top-down approaches (Esman and Uphoff, 1984). If the specific "learning" characteristics of these organizations are acknow-

⁵ In Senegal, the *Loi sur les mutuelles de santé*, voted in 2003, is not yet in force because application decrees have to date still not been promulgated.

⁶ In some countries, this process is complex because various ministries (e.g. Public Health, Social Protection, Labour, Social Affairs) claim administrative responsibility for MHOs.

ledged – especially in the democratization processes – this also means that more time is needed to make decisions when everything depends on the goodwill and choice of the members. It also explains why it is sometimes difficult for MHOs to be effective in the short run.

Social factors play a role in limiting the model's effectiveness. For instance, membership in an MHO is often determined by attributes like religion or gender (Jütting, 2002). This will always present a problem for MHOs, especially in their efforts to enlarge membership. In the same way, measures have to be taken to protect the scheme from pitfalls such as adverse selection, moral hazard, over-prescription or fraud. However, many of these measures tend to be unpopular. Develtere et al. (2004) reported member dissatisfaction with initial waiting periods, mandatory affiliation of all family members, identity and insurance status verifications and exclusion of certain treatments. In self-managed insurance schemes like MHOs where the proximity between members is a trust factor, it is not difficult to imagine the difficulties in the application of these technical measures.

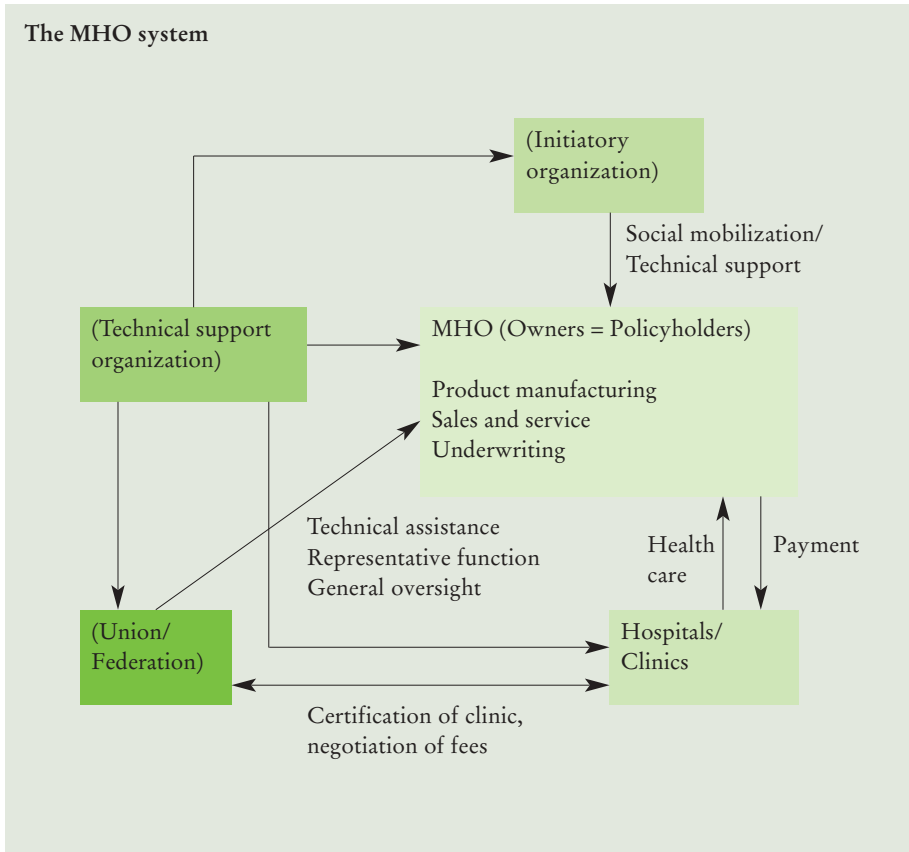
MHO membership is normally voluntary. However, faced with the problem of low enrolment, some organizations have attempted to make membership compulsory for the entire target group, or automatic (e.g. once you are member of an organization, you become a member of the MHO). In most cases, these attempts failed and were discontinued because of members' refusal or because of a lack of capacity to ensure implementation.

The emphasis on financial accessibility or affordability results in low premiums and limits the benefit packages. Increasing the premium level could implicitly exclude current and potential members. This limitation is not intrinsic to the MHO-model, but linked to the MHOs' primary target group, namely low-income people.

Last but not least, MHOs often have complex structures due to the diversity of actors involved, as illustrated in Figure 25. Initiating organizations play a role in the social mobilization process and can provide some technical support to MHOs. Technical support organizations (national or international, on a permanent or sporadic basis) are also involved and can have a significant influence when the scheme is new. Where they exist, federations strive to assume the responsibilities of the technical support organizations over time. Finally, the healthcare providers play an instrumental, although not always constructive, role. The variety and diversity of actors – each with a necessary short-term function – complicates an already complicated decision-making process.

Figure 25

The MHO system



5.3 External support-related problems and limits

The development of community-based health insurance cannot be analysed without considering the pivotal role of technical and financial support organizations. External support organizations are diverse.⁷ Nevertheless, with a few exceptions, some common features of the external support role can help explain the MHOs' current situation.

Microinsurance was a new field for all external support organizations involved in establishing them. Some were specialists in health insurance in their own countries (France, Belgium), but did not have specific experience in Africa. Others had experience in Africa, but in other domains such as microfinance. For all of them, support of health insurance for populations excluded from social protection schemes represented a new area of social engineering.

⁷ The term "external support organization" refers to technical and/or financial support organizations. This section only deals with one aspect of their interventions, namely direct support to MHOs. For instance, the political input provided by ILO/STEP and others to influence social protection reforms is not addressed in this chapter.

Some choices were made. With a few exceptions, there was an implicit consensus that the benefit package and premium amount should be balanced from the beginning. Schemes do not offer more benefits than what members are willing or able to pay for. To a certain extent, financial sustainability and community-based learning processes were preferred by external support organizations to artificial short-term successes.

The social participation process needs time. However, the process is often difficult to support because of the limited timeframe of an external intervention and the contingencies of funding agencies. In practice, this has meant that support organizations have often had to stop or restrict their support at a time when MHOs still needed to strengthen their activities or their governing bodies, or overcome difficulties.

In general, support organizations did not attach equal importance to social and technical aspects. The community-based approach implies social mobilization, education, social cohesion and ownership. This led to an important emphasis on the social aspects of health insurance to ensure social viability and the permanence of the dynamics created, while insurance product design was sometimes neglected. This can be explained by considering the circumstances (i.e. limited choice between healthcare facilities, insufficient knowledge of healthy behaviour, low income, etc.). In addition, it took time to develop relevant methodologies, appropriate management tools and monitoring systems.

From the beginning, external support organizations made some rational choices, motivated by institutional sustainability preoccupations and/or cost-reduction constraints. Apart from not subsidizing claims, intensive financial support was often limited to the start-up phases. However, logically, leaders of fledgling MHOs faced many problems they could not solve due to their lack of know-how and experience.

Most support organizations use participatory approaches, which require an active involvement of the target group during the set-up phase, including data collection for the feasibility study. However, it is not easy to find a balance between the technical expertise needed for a feasibility study and the necessary ownership by the MHO's members. Self-management and voluntary work are also part of this participatory approach, which creates a set of related problems as discussed above. There are solutions, for example paid professional or remunerated officials, but they raise the stakes for MHOs in terms of cost, autonomy and sustainability, and for the support organizations' exit strategies.

Many MHOs were created in isolation; networking with other MHOs and/or social protection systems at regional or national level was often not planned at the outset. Some external organizations did not originally favour this networking. Although some intrinsic features (especially the community-based one) could explain this oversight, it is now recognized that efforts have to be made to forge structural relations between the actors early on in the process. This is not easy, nor is it without risks. Ideally, each MHO should build its own identity before becoming involved in upper-level dynamics.

These observations demonstrate why it has been, and still is, difficult to find the appropriate balance between the nature of community-based organizations and the design of the support intervention.

6 What is the added value of this model?

The community-based model is not the easiest way to organize health insurance. The West African context, with its nascent democratization process, high levels of poverty, mismanaged healthcare facilities and limited availability of skilled human resources, certainly does not facilitate the implementation of this model. So what is its added value?

MHOs are more than just institutions selling insurance to clients. In this respect, MHOs have to be assessed not only on the effectiveness of their insurance provision function and their potential role in the extension of social protection, but also taking into account the effect of their social participation processes.

Access to healthcare in Africa (and elsewhere) is not only a matter of insurance. Most existing statutory social protection systems in Africa are not effective (*see Chapter 1.3*). Reform processes are underway in many countries, but it is obvious that successful social protection reforms need to include input and representation from the population. It is also recognized that reformed social protection systems will include a range of public as well as private tools (ILO, 2002c).

Intrinsically, MHOs have some added value. Through their non-profit nature, their non-exclusion policy and their low premium, they guarantee access to some services, even if the coverage is limited. Participation not only contributes to the client's satisfaction, but also to empowerment and learning. In this respect, MHOs create advantages through their embedded control and participation mechanisms. Although research on participation mechanisms is still required, MHOs are part of the democratization process. Moreover, one advantage of this model is its influence over the management of health services (management transparency, security of financial resources,

etc.) and its ability to improve healthcare quality (*see Box 79*). The size of the MHO strongly reinforces this power. While the power should not be overestimated, some pressure can be put on health systems, especially when MHOs are organized into a federation. For example, many MHOs are taking action to get rid of public agents who do not carry out their duties.

Box 79

The power of collective action

In 2004, when asked to renew their premiums, no members of Réseau Alliance in Borgou-Benin wanted to do so. The reason was that the midwife of the dispensary contracted by the MHO had decided that she would not attend to pregnant MHO members during the weekend. The official of the network “Alliance Santé” organized a village meeting with both members and non-members. The midwife had to apologize to the participants and commit herself to avoiding any discrimination in the future. Following this meeting, the number of insureds increased from 1,000 to 1,200.

This power also exists in the negotiation of prices for services delivered to members. Some MHOs have obtained lower fees for their members. Although this is not always the case, this fee reduction can be seen by health-care facilities as an added value in being more financially accessible to the population. Empowerment of the members who learn to influence the quality of healthcare is also an added value for MHOs compared to non-self-managed modes of insurance.

7

Conclusion

Mutual health organizations, a community-based model for insurance provision, have been active in West Africa for over a decade. For many people, it is the only “formal” social protection they have. The model is fraught with problems, but a clear understanding of their origins helps to identify solutions that can enable this approach to fulfil its potential in being more than just an insurance mechanism.

Nowadays, other models (e.g. health microinsurance products offered by microfinance institutions like AssEF in Benin) are also seen in West Africa. Many try to adopt the community-based philosophy of MHOs and inherit the advantages of the model, while increasing effectiveness by improving the functioning and increasing the scaling-up potential. Although it is too soon to judge whether these new approaches will succeed, this evolution toward a more diverse landscape of health microinsurance models is positive and could provide wider coverage through collaboration with NGOs, microfinance institutions, cooperatives and the like.

Despite this positive diversification, some questions remain. For example, how can community-based health insurance systems be better supported to fulfil their multi-purpose functions? Moreover, are these health microinsurance systems relevant without a broader redistributive social protection mechanism?

Institutional options for delivering health microinsurance

Ralf Radermacher and Iddo Dror¹

The authors appreciate the detailed and useful comments provided by Klaus Fischer (Laval University), Bénédicte Fonteneau (University of Leuven) and Michael McCord (MicroInsurance Centre), as well as the stimulating discussions with David Dror (Erasmus University Rotterdam) and Gerald Leppert (University of Cologne).

Health insurance entails the transfer of health risks in return for a premium payable in advance. This succinct description suggests that the arrangement entails flows of funds and information in two directions: from the client to the insurer and from the insurer to the client. The party with the most control of these flows of funds and information can influence the business process to its advantage.

This notion that one party would seek an advantage over another implies that conflicts of interest can occur between insurers and insured. But is this the case in health microinsurance provision? And if so, does the institutional option (model) for delivering health microinsurance have an influence on such conflicts of interests and efficiency in the provision of insurance? This chapter looks at these questions by offering a basic typology of the different business process options identified in health microinsurance provision. Such a typology will help identify conflicts of interest and remedy inefficiencies in the smooth bi-directional flow of funds and information.

This chapter first summarizes the main types of health microinsurance providers and then analyses their relative effectiveness in meeting the needs of the low-income market over the long term.

I Institutional options

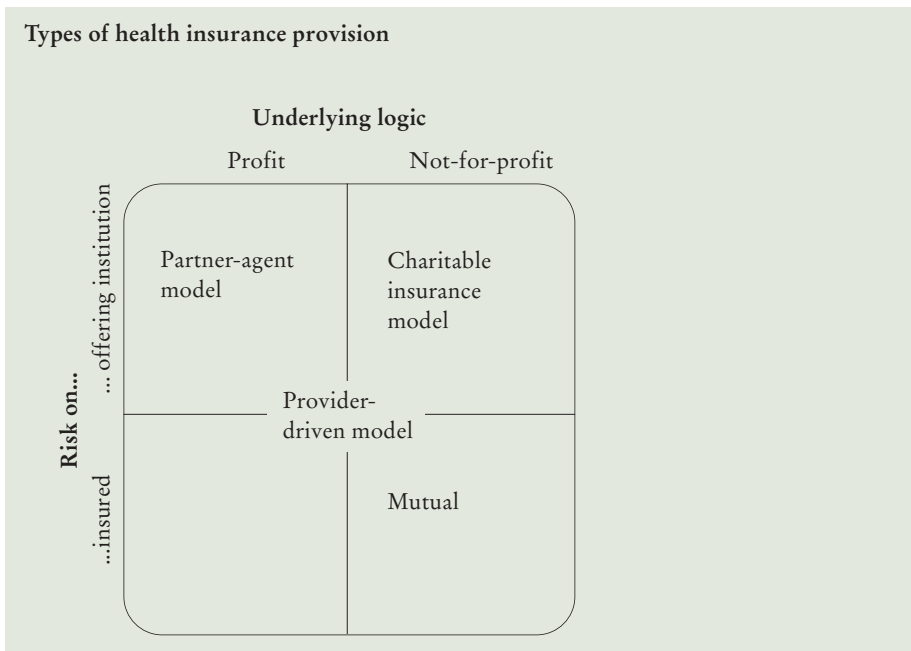
All insurers must satisfy the basic value proposition, namely that they reduce the long-term cost of the risk for the insured. An additional requirement, which is specific to microinsurance, is that the type of organization should function effectively within an environment of low premiums. As discussed in Chapter 2.1, such a situation might lead to severe rationing of benefits and, when coupled with a broad variety of insurance needs for the heterogeneous

¹ References in this chapter to the following Indian microinsurance schemes are drawn from the authors' experiences: BAIF, Arogya Raksha Yojana and Voluntary Health Services.

low-income market, result in product fragmentation to suit many small groups of clients. To reduce the long-term cost of risk, the insurer has to aggregate many individual risk profiles that have different statistical distributions and that can be diversified over time. While some types of microinsurance providers can fulfil the requirement for large numbers more easily than others, they might suffer from other weaknesses in the business process.

The typology presented in this chapter considers four main providers of health microinsurance: 1) licensed insurers operating the “partner-agent” model, 2) the charitable insurance model, 3) healthcare providers that also operate health insurance and 4) the mutual model discussed in the previous chapter.² This typology results from distinguishing organizations along two dimensions: a) the primary motivation for entering the market, since this motivation influences the design of the business process and hence the product, and b) the entity bearing most of the risk of losses, as depicted in Figure 26. The description of the organizational models that follows contains a discussion of their advantages and disadvantages in fulfilling business-process functions, and their effectiveness in minimizing (or not) conflicts of interests within the system. The analysis also takes into account certain differences, such as governance mechanisms.

Figure 26



² The authors recognize that there are certainly other institutional arrangements as well, but the typology described here emerges most clearly from the case studies. Furthermore, one could divide these four provider types into sub-categories, some of which would have “hybrid” characteristics of more than one provider.

1.1 The partner-agent model

As described in Chapter 4.2, under the partner-agent model the relationship between the policyholder and an insurance company (“the partner”) is facilitated by an intermediary (“the agent”) such as an NGO, a microfinance institution or any other organization with close contacts to the target group. Owing to the regulatory conditions discussed in Chapter 5.2, examples of the partner-agent health microinsurance model are common in India, including:

- VimoSEWA and ICICI Lombard
- Shepherd and United India Insurance Company (UIIC)
- Karuna Trust and National Insurance Company (NIC)

The insurance company is responsible for all decisions affecting product manufacturing, sales, servicing and maintenance of long-term sustainability, i.e. it carries the risk. Although it may consult the agent organization when designing a product, the insurer maintains control over the strategic operations that define the risk transfer mechanism.

The agent deals with sales and product-servicing within the boundaries of the products that the insurance company is allowed to sell, and at commissions that meet the regulatory limits or are agreed on with the partner. Agents have better knowledge of (and ties to) the target market, but their primary role is to represent the insurer to the clients. This is an area where conflicts of interest might arise, as the agent organizations usually regard themselves as advocates for their clients, and might feel uncomfortable communicating the insurance company’s position.

Consider the case of a claim settlement procedure, where the agent needs to defend the insurer’s position to its clients. If a conflict arises over whether a claim is valid and should be paid, the agent might need to agree with one side, running the risk of alienating the other. Usually, its position as an agent of the insurer means having to side with the latter, and communicate the rejection of a claim to the client. If such cases occur frequently, agents might find their reputation in the community damaged and the community’s trust in them – the very attribute that attracted the insurer to the agent – will diminish or be lost. Therefore, in practice, agents such as VimoSEWA occasionally cover claims from their own coffers if they feel that the claim rejection is unjustified.

Another potential conflict arises with adjustments to the premium levels. For example, after BAIF's claims ratio had exceeded 100 per cent, UIIC decided to increase the premium charged to BAIF's insured clients by about 80 per cent. Unable to justify such a rise to its clients, BAIF decided to turn its insurance scheme into a mutual.³

As illustrated in Figure 27a, neither clients nor healthcare providers have direct input into the production process, and bear no responsibility for long-term sustainability. The agent's role is usually also confined to sales and after-sales service, although the latter is sometimes dealt with by the insurer directly or through a third-party administrator (TPA). For example, the Arogya Raksha Yojana scheme near Bangalore, India is linked up with ICICI Lombard for health insurance, and has contracted a TPA for administration (*Figure 27b*).

In the partner-agent arrangement, each side can benefit from the comparative advantages of the other, but a couple of inherent problems often remain unresolved. An insurance company is usually interested in selling a pre-designed product (often a scaled-down version of its products for the formal sector). This type of product is easier for the company to monitor and does not need to be priced anew. Some insurance regulators also require new products to be registered and few companies are willing to do this for every agent/community; usually, only large agent organizations have the negotiating power to push for a tailor-made product.

This lack of flexibility in product design is particularly important because, as discussed in Chapter 2.1, product features are more likely to influence adoption among the target population in health insurance than in life or property insurance. However, this problem can be solved in the partner-agent model. Due to its proximity to the target group, the agent should be well placed to explore the actual demand, while the insurer can use its actuaries to turn the demand into a well-priced product. This was the arrangement for Karuna Trust, which engaged in a detailed demand analysis before linking up with NIC. Although the benefits demanded and the price negotiated caused a severe headache for NIC's actuaries, the insurer was willing to pilot this scheme. Similarly, Shepherd and UIIC designed a benefit package together making use of their respective competencies.

³ BAIF is an NGO working on rural development in India. Coming from cattle breeding, it subsequently expanded its activities to a broad variety of services and now provides microfinance and, in one pilot area, life and health microinsurance.

Figure 27a

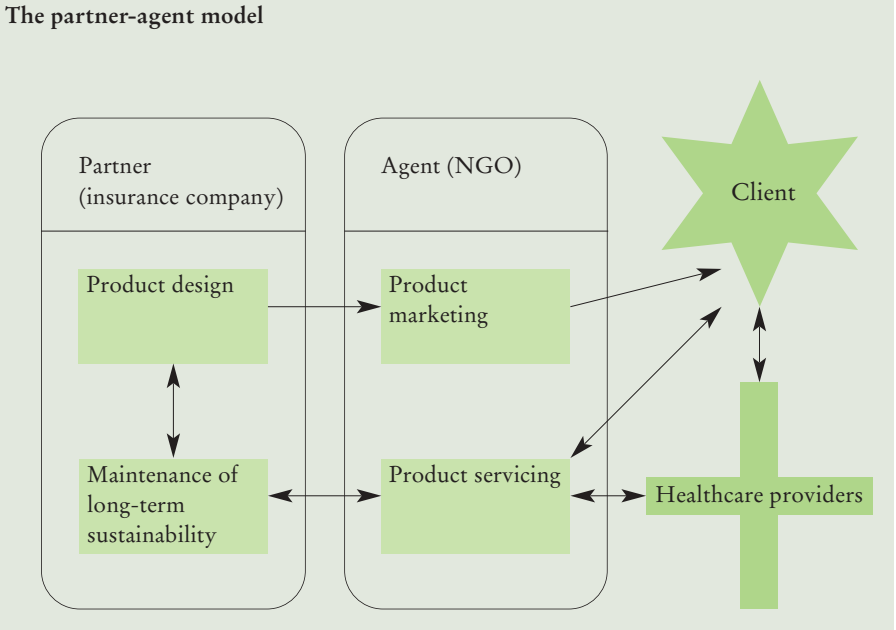
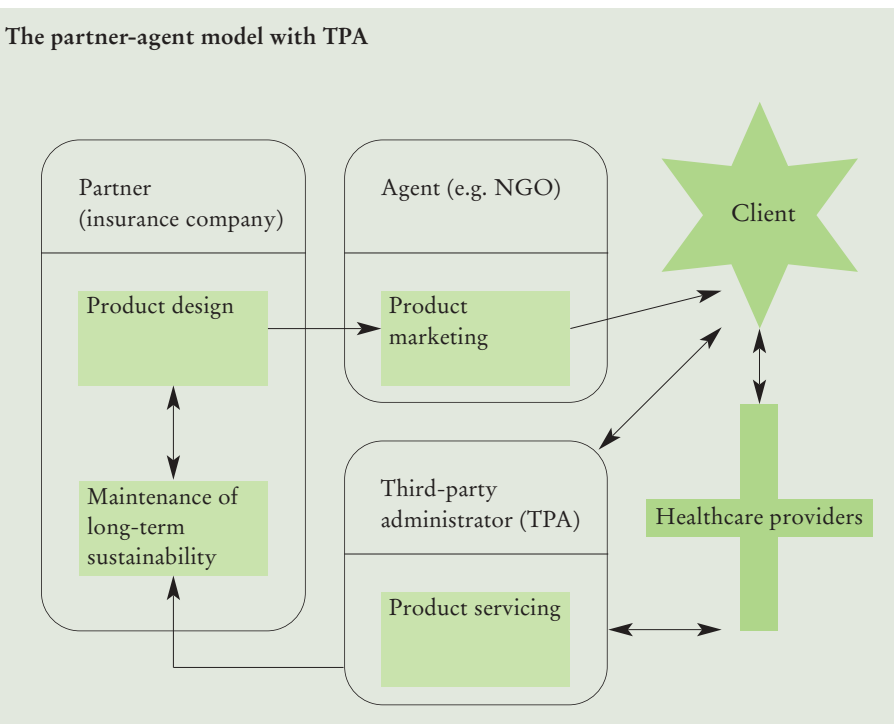


Figure 27b



For health microinsurance, the agents' real comparative advantage (and hence their source of attractiveness for the insurer) is highlighted in the sales process. Insurers, which often lack a relationship of trust and access, both physical and psychological, to potential clients, rely on the agent's proximity to the market and the trust built up over the years through the agent's other operations. However, market penetration is one thing, but complete transparency another: clients quickly realize that there is little incentive for them to provide information about their health status or about a neighbour who they know is withholding information, and so the flow of information in both directions is incomplete in the partner-agent model. This constitutes an increased risk to insurance companies for which their shareholders (logically) expect to be compensated by increased returns (invariably, *ceteris paribus*, leading to higher premiums). Higher premiums in turn result in clients' increased demand for "value for money" and thus amplify moral hazard (again a higher risk for the insurer). Thus, a vicious cycle of dysfunction can evolve which may cause the opportunities inherent in this model to be squandered. For as long as risk and returns are not balanced from the insurer's perspective, there will be no incentive to enter the market in a meaningful manner.

This incentive problem is amplified when it comes to product-servicing and claim verification. The insurance company may expect the agent to verify the claims, and if so hopes that the strong ties of the agent with the target groups will ensure a good flow of information. However, as in any commercial insurance scheme, clients have no incentive to provide information that will benefit the insurance company at their (or their neighbour's) expense. Clients might even consider it legitimate to cheat a large company in a distant city following the logic: "we are poor and they are rich, so they can pay." This manifestation of the "*them and us*" paradigm implies an attachment to certain networks, norms and trust at the community/client level – which captures the essence of the social capital concept – at least from the perspective of Putnam (1995) and his followers.⁴

As insurance companies experience this problem with clients from every market segment, they establish monitoring mechanisms for verifying claims. However, these mechanisms are costly, and in the context of microinsurance may be prohibitively expensive to the point where affordability for the poor

⁴ The concept of social capital has been the subject of much interdisciplinary examination over the decade following Robert Putnam's 1995 article "Bowling alone: America's declining social capital". It is generally accepted that if authors wish to use the term, they should define how they will use it. While it is not within the scope of this book to develop a definition of social capital in the context of health insurance for the poor, references to some useful reviews of the subject by Farr (2004), Manski (2000), Portes (1998), Sobel (2002) and Woolcock (1998) are included in the bibliography.

could be jeopardized. Furthermore, attempting to solve this problem according to the logic of the traditional business process for high-net-worth clients is the hallmark of scaled-down commercial insurance products – hardly an innovative health microinsurance solution.

To solve this problem, VimoSEWA trained its people in claims investigation techniques, established a claims committee with appropriate expertise and persuaded its insurance partner to allow it to adjudicate claims. However, more can be done: synchronizing the clients' incentives with the incentives of the insurance company (e.g. through profit-sharing arrangements) modifies the business process in such a way that the problem might not arise in the first place, as clients would then have an increased incentive to keep information flowing (perhaps not about themselves but about others who are cheating the system).

A similar (though not identical) application has been extensively documented in the related field of microfinance, whereby mechanisms (notably joint liability and contingent renewal) have been put in place to use the power of communities to compensate for the information advantage customers had over the lender (Van Bastelaer, 2000). This is an excellent example of social capital at work – replacing traditional, more formal (and costly) means of evaluating creditworthiness used by commercial banks with peer pressure and character-based lending (DeFilippis, 2001).

The main point is that a true sense of ownership and “buy-in” among the clients (preferably through leveraging communities' social capital) is indispensable for a successful health microinsurance scheme, and might be even more important than in other business areas of corporate insurance companies.

1.2 The charitable insurance model

Charitable insurance models cover a wide range of institutional options, which all share two important features: (i) being non-profit and (ii) not putting the risk on the insured. It is especially the first feature that distinguishes this model from the partner-agent model (this is at least true for the insurer's side), and from some healthcare provider-driven models where the prime objective is to increase utilization of their facilities. The degree of risk on the insured and their involvement in the business process distinguish it from the mutual model (to be discussed later in this chapter). Providers of this kind of insurance can be NGOs, religious associations or any other well-meaning organization. Thus, this model can be applied to some government-supported initiatives as well.

The motivation for establishing the insurance scheme is to increase clients' access to care. The motivation is purely social, resulting primarily from the development background of these organizations. The paternalistic and social characteristics of the charitable model do raise some potential conflicts of interest, notably that of placing priorities of the clients behind those of other stakeholders (such as donors or NGO management). Furthermore, in situations where sustainability is based on permanent external financing, the scheme may neglect the education of its clients on proper insurance mechanisms, which might make it difficult to create an insurance culture among the target market.

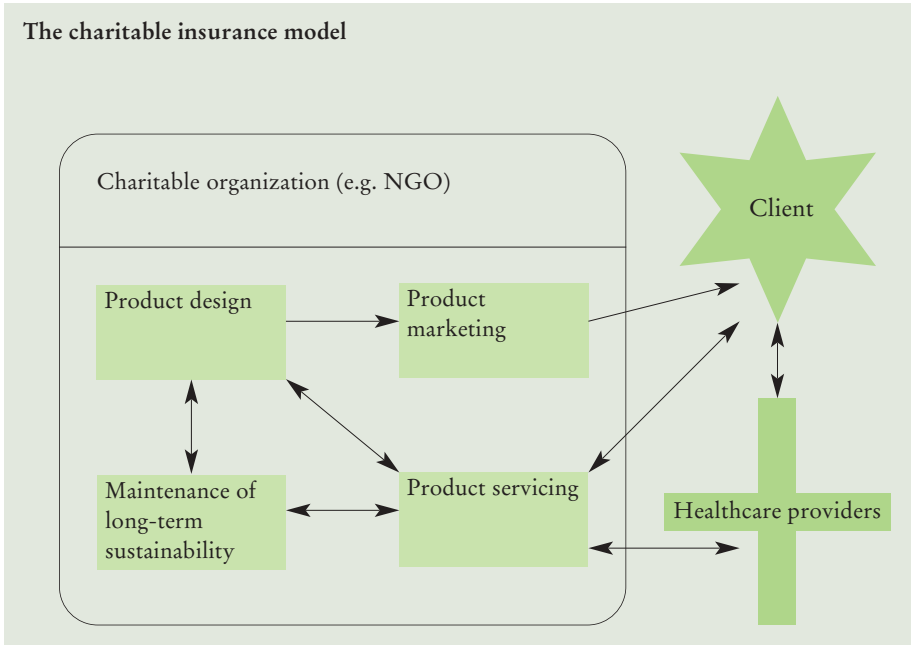
As most of these organizations have worked with the target group for quite some time, they are familiar with the requirements of prospective clients. However, turning this into an actuarially-priced product is difficult since these organizations usually lack insurance expertise. The health insurer bears the risk of losses. Profits generated in some years are kept as reserves for future losses. All activities of the business process are performed by the offering institution, sometimes with involvement of the target group. The responsibilities of the charitable insurer are illustrated in Figure 28.

VimoSEWA operated its health insurance under this model from 1996 to 2002. In 1996, VimoSEWA found the health insurance products available on the market unsuitable for its clientele. The administrative procedures did not at all respond to the needs of poor women who had to wait a long time before being reimbursed. Thus, VimoSEWA terminated its partner-agent relationship and became its own charitable insurer, but after the 2001 earthquake in Gujarat, the limits of being a small-scale stand-alone insurer became obvious and VimoSEWA entered a new partner-agent relationship.

Yeshasvini Trust, in India, is a mixture of the charitable insurance model and the provider-driven model (discussed below). Initiated by healthcare providers, it is now operated by a trust in which the cooperative sector of Karnataka is equally represented. The healthcare providers shaped the benefits, which are still provided today; the cooperative sector shaped the sales and business process. While the influence of the providers on the product manufacturing process makes it a provider-driven model, the fact that the trust as a whole, which bears the risk (supported by the Government of Karnataka), is not-for-profit and conducts all parts of the business process, makes it a charitable insurance model.

Figure 28

The charitable insurance model



For many charitable insurance schemes, achieving sustainability is a major challenge due to their social background. For instance, they may find it more difficult to reject claims, even if the claim is not fully justified. This is due to what is sometimes referred to as the “dirty work hypothesis”: managers of charitable institutions might feel that they threaten the institution’s reputation by rejecting claims since, unlike in the partner-agent model, the charitable institution cannot blame anyone else to justify an unpopular decision.

Some charitable organizations take this social motivation logic even further, to the point of not even considering sustainability of the insurance scheme an objective. Instead, it is simply assumed that losses will occur, and will need to be covered with external subsidies.

This social interpretation of this kind of organization’s mission also affects the design of its business processes in insurance: the flow of information in the sales process is mainly unidirectional towards the client. Information on how to claim benefits is provided, but no information about pre-existing diseases is sought. The distribution process is usually conducted through the organization’s own staff who also have other duties. Voluntary Health Services (VHS) in Chennai (India), for example, distributes its insurance product through mobile health workers or in its health centres. Its objective is to cover those who need it most, not necessarily balancing the bad risks with good risks to stabilize the risk pool.

Charitable organizations usually agree to relatively unrestricted provision of benefits and product-servicing is also kept simple. For instance, VHS and the Society for Social Services (Bangladesh) both operate their own health facilities and clients are obliged to use them. However, unlike provider-driven models (described below) the motivation here is not to increase the utilization of their own (commercial) facilities, and consequently their financial viability, but rather to ensure that their insured population has access to health services.

Maintenance of long-term stability is arguably the weakest point of the charitable model. Often management does not regard financial stability as desirable: “We do cherry-picking: we only pick the bad cherries,” a manager of VHS points out – nicely illustrating the different underlying mindset. The Society for Social Services can in no way cover the administrative costs of its health programme through insurance. They amount to over 2,000 per cent of the premiums collected! Thus, their means of ensuring sustainability is through a donor rather than a market-based solution (such as reinsurance).

1.3 The provider-driven model

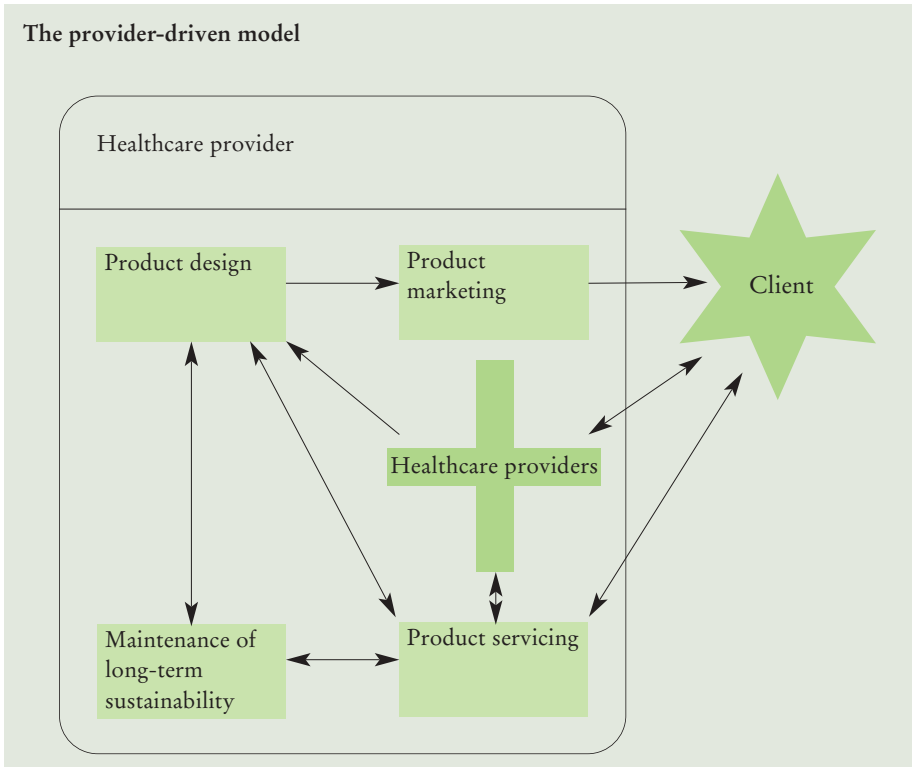
Providers of care (e.g. hospitals, clinics) may launch an insurance scheme to generate larger volumes of business in dedicated facilities, as well as to open up access to healthcare at different unit prices for different segments of the target population (*see Figure 29*). The unique feature of this model is the involvement of the healthcare provider in the design of the business process (including the financing side).

This is an important feature: a healthcare provider directly deciding on the benefit package is significantly different from an insurance company setting up its own healthcare facility, or directly employing providers to service a product. The difference might seem rather theoretical, but the question of ultimate control over the design of the benefit package is not trivial. Consider the case of open-heart surgery – if the decision-maker is a surgeon, whose services are not in great demand due to the high cost of operations, the likelihood of this benefit being included in the package is higher than if the decision is taken by insurance professionals or clients.

This explains why many provider-driven schemes restrict clients’ choice to the provider’s facility or its health professionals, or like Grameen Kalyan and BRAC MHIB in Bangladesh, significantly limit the benefits available outside their own healthcare providers. The clients pay their premium to the healthcare provider, which in turn offers clients a financing mechanism that enables them to consume health services, presumably in a more cost-effective manner than paying for them out of pocket. At the same time, the provider benefits from this arrangement in several ways: a) it increases its potential

Figure 29

The provider-driven model



market by enabling more people to use services, b) the provider restricts the choice of customers to its facility and c) the provider receives revenue from those who would otherwise have not sought treatment, or would have done so elsewhere, or to whom it would have provided services anyway – but for a lower price or for free.

In some schemes, the premium is used directly for operating the health facility, while the provider commits to providing certain benefits to the clients if needed, with provider payment on a capitation basis. Hence, the risk in bad years rests with the healthcare provider which then needs to provide the services. In good years, the surplus is absorbed by the healthcare provider. In these payment systems, the provider has an incentive to underprovide or compromise on the quality of care.

In other schemes, the premium collected is released to the healthcare provider according to the services rendered or cases treated (fee-for-service, case-based payments). This mechanism requires a stricter separation between insurance and healthcare provision. For instance, Yeshasvini Trust fixed the prices for more than 1,600 operations and reimburses the network hospitals according to the surgery carried out (i.e. case-based). Fee-for-service is applied in the Nkoranza Community Health Insurance Plan, Ghana (*see Box 80*).

Box 80

Nkoranza Community Health Insurance Plan

St. Theresa's Hospital is the major provider of inpatient services in the district of Nkoranza in rural Ghana. In 1992, it launched the Nkoranza Community Health Insurance Plan, a provider-based health microinsurance programme, in response to the inability of residents to pay out of pocket for health services, especially hospitalization. The insurance covers inpatient services at the hospital in full including the cost of prescriptions for drugs not available in the hospital, referral to other hospitals and some outpatient services.

When clients seek care, they hand over their insurance card to the treating doctor or nurse who writes the insurance number on the patient's admission card. Based on the services rendered (fee-for-service) a monthly bill is sent to the insurer. The prices for the services are fixed by an external body, the Diocesan Health Committee, on an annual basis and are valid for all Catholic Hospitals in the region. The insurance reimburses the hospital for all services rendered, but is not entitled to check their appropriateness. Although not observed in this scheme, the fee-for-service mechanism with institutional splitting (between insurer and provider) provides an incentive for the provider to over-prescribe services to increase financial returns.

Source: Adapted from Atim and Sock, 2000.

Most healthcare providers do not have the administrative (or sometimes the financial) capacity to run a viable health insurance scheme. Pricing products actuarially is certainly a weak point even though the data available about healthcare expenses might be relatively good in this model. The main problem of the model is in product servicing: in the case of fee-for-service payments, the healthcare provider might have an incentive to provide more services than necessary, while the insurance provider needs to maintain its long-term stability. The unification of roles of provider and purchaser of services may thus create conflicts of interest.

1.4 The community-based/mutual model

Mutual benefit societies, also referred to as community-based health insurance schemes or mutual health organizations, are voluntary non-profit systems of risk-spreading based on the ethics of mutual assistance and solidarity (see *Chapter 4.3*). This model is based on the premise that the risk is borne by the insured, who are the owners of the scheme, and that profits are in some way retained for the benefit of the insured.

However, community-based and mutual schemes are not identical. The community-based model is usually made up of a small, local group formed on the basis of the social ties developed in day-to-day interaction. The management has little professional expertise in insurance and the degree of involvement of the members is usually quite high. Mutual schemes, on the other hand, have a long history as providers of social security.⁵ They are often built on religious or common political lines and provide insurance services to their members. Mutuals are often much larger than community-based schemes and usually have professional management. Due to the group size, and the consequent absence of personal links between the members, there may be less social cohesion in mutuals than in community-based schemes.

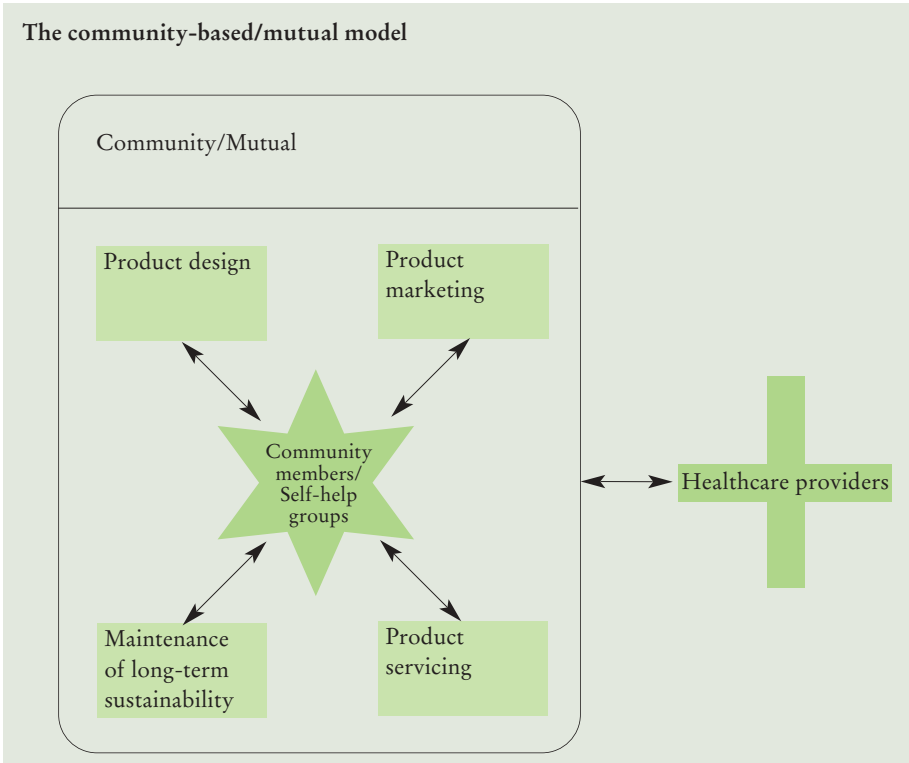
In the community-based/mutual model, clients or members play the central role. As illustrated in Figure 30, they are responsible for all aspects of product manufacturing, sales and servicing, as well as for the maintenance of long-term stability. Members are both the insured and the insurers, as the group underwrites the risk collectively. As owners of these societies, members are actively involved in management and decision-making. They have a direct influence on determining the scope of coverage and the size of contributions. This first-hand knowledge of needs and preferences gives mutual schemes a special advantage in designing the products. The involvement of the members ensures a high degree of satisfaction with the product; but this is conditional on true and representative inclusion in the design process, as well as on fair and transparent management of the scheme. At the Union des Mutuelles de Santé de Guinée Forestière (UMSGF), the general assembly of the members decides on the benefits covered. However, to design and operate an insurance system, specialist knowledge is necessary and this is the Achilles' heel of many mutual schemes. Sometimes apex bodies, e.g. in the form of a secondary cooperative, are set up to provide technical assistance (see Boxes 75, 76 and 77 in Chapter 4.3).

As member-run organizations, mutual benefit societies are based on the principles of self-help, self-administration and self-responsibility. According to the latter principle, the members bear the actuarial risk and are liable for potential losses. By the same token, profits remain in the system to the advantage of all members. This loss- and profit-sharing model suggests that the interest of the individual remains aligned with that of the group, strengthening social cohesion in the group. This model, especially when operated in small communities, usually lowers the costs stemming from

⁵ Mutuals, derived from the French concept of *mutuelles*, are known by many names: friendly societies in Anglo-Saxon countries (and their former colonies), fraternal societies in the United States, *Versicherungsvereine auf Gegenseitigkeit* in Germany, *sociedades de socorro mutuo* in Spain (and its former colonies), and so on.

fraud, moral hazard and adverse selection. This is due to high levels of social cohesion, which is usually more prominent in small groups, where social interactions tend to be both more important and easier to trace (Sobel, 2002), and translate (in the health microinsurance context) into an informal and frequent flow of information. However, this flow of information can create a privacy issue as well, since people might be afraid of social exclusion in case of certain illnesses – for example, in the case of HIV/AIDS and mental illnesses – and thus prefer not to rely on the benefits of the scheme.

Figure 30



Another drawback of such mutual schemes is their smaller group size: small groups experience greater uncertainty about claims expenses and are more vulnerable to catastrophe risk. While social control may be a suitable instrument to reduce moral hazard, successful risk spreading – or at least a transfer of accepted risks – requires merging with other risk pools or access to other forms of reinsurance. Further aggregation of risk would not only lead to increased financial stability, but also result in lower premiums through decreased capital loading (Dror et al., 2005a); however, this kind of reinsurance is usually not available.

In a member-owned institution, the responsibility for stability rests with the member-run management, which is sometimes delegated to professional managers. According to the ownership principle, all members should ideally feel committed to the stability of the system. The notion of ownership in terms of identification with the system and a sense of personal responsibility may represent a major advantage of community-based schemes. To strengthen the personal responsibility and prevent losses due to over-utilization, UMSGF has developed a “loss ratio trend tool”, bringing together statistical information to inform members and strengthen their feeling of ownership.

However, personal responsibility can easily get lost when mutual organizations grow and become more professional. In this process, the member-run administration of community-based schemes is replaced by professional managers who might develop their own set of aims rather than focus on the members’ objectives.⁶ Managers have an incentive to expand the scheme, as this might enhance their remuneration, reputation and power. Although this is good in terms of stabilizing the financial viability of the scheme, the voice of the individual insured can no longer be heard. It becomes increasingly difficult for insured members to monitor their own scheme due to information asymmetry and asymmetry in skills between the professional management and themselves. The scheme is no longer member-ruled but taken over by managers. This can result in members losing their sense of ownership, and thus in the loss of many advantages of the mutual scheme, except that profits still remain with the group of insureds.

2

Value, interests and conflicts in the insurance business process

Besides these four main types, a number of further possible subtypes exist, all with their own combinations of strengths and weaknesses. However, an analysis of these main models illustrates the key conflicts of interest that emerge in the provision of health microinsurance. In microinsurance, efficiency might be even more important than in conventional insurance, and therefore one must pay special attention to the conflicts of interest in the business process. If these conflicts remain unresolved, they add costs to the insurance arrangement. Using the framework presented in Chapter 2.1, this section considers the conflicts of interest and efficiencies in the business process of the different delivery models.

⁶ The potential conflict between members and managers is extensively discussed in cooperative literature, for example: Dülfer (1995), Vierheller (1983, 1977), Neumann (1973), Eschenburg (1972) and Hanel (1992).

2.1 Product design: Offering value for money and responding to client wishes

Health microinsurance clients generally prefer broad coverage that includes low-cost, high-probability events (e.g. outpatient coverage, pharmaceuticals), while insurers like to cover rare events. This conflict of interest is most apparent in the partner-agent model, where the main aim of the insurer is usually profit, and where less frequent claims help profit margins by keeping administrative costs low. For example, the plans offered by VimoSEWA/ICICI Lombard and Shepherd/UIIC only cover hospitalization. The health microinsurance products offered by commercial insurers typically focus on this kind of benefit.

Commercial insurers are reluctant to deal with endless numbers of small claims, especially when an arrangement with unregulated healthcare providers would produce additional monitoring costs. However, the insurer, which maintains control over product design, also finds it hard to know what the insured want: what price are clients willing to pay and for what benefits? Here, the agent can help resolve a part of the problem. The more the insurer is willing to involve the agent – on behalf of the client – in the design of the benefit package, the more likely the product is to respond to clients' needs. However, insurers may consider some low-income market segments too small to justify a costly adaptation process. Rather, the insurer will be tempted to persuade agents to sell products already developed.

The provider model would possibly be better placed to be aware of client priorities if consumption of health services were systematically registered and analysed prior to launching the insurance product, even though there is, generally speaking, little data on willingness to pay and priorities of the client. Furthermore, depending on the type of services they offer, providers might adopt a more flexible attitude to the clients' desire to have low-cost, high-probability events (e.g. outpatient care) included in the benefit package. This is usually true for charitable models as well, and can apply to community-based models too. However, the perspective in defining the benefit package is different: in provider-driven models, services are included in the benefit package only if they are actually offered by the healthcare provider. Therefore, the provider, not the client, is the starting point. Charitable and community-based insurance providers might be more likely to take the clients' needs as the starting point, as their concern is neither profit nor developing their own healthcare facility, although the charitable model might not consider it necessary to involve the community as it plans to assume the risk in any case.

The community-based model, which by definition involves the client in the benefit design process, has a strong advantage in knowledge of clients' needs and willingness to pay. The insurance product in this model is likely to respond more directly to the clients' needs and may even increase their willingness to pay. However, it has to be stressed that this strength of community-based models can only be exploited with the participation of the members, which does not always occur in practice, especially when these associations expand.

Another conflict of interest can arise in the provider-driven model when the price of services is negotiated, as the same institution represents both the purchaser and supplier of services. Although one assumes that most provider schemes use their knowledge of their own cost structure for the benefit of the client, a basic conflict of interest remains and special attention needs to be paid to it. The (partly) provider-driven Yeshasvini Trust, for example, has fixed flat rates for surgery for all 150 hospitals in the network. However, not all types of surgery are offered in each clinic, and some clinic managers claim that hospital managers participating in the administration of the trust ensure better rates for operations that are primarily carried out in their hospitals. While this may be a case of "the neighbours' grass is always greener", it is an issue that large provider networks need to sort out if they wish to increase their efficiency.

The frequency of premium payment is another area where the interests of the insurer and the insured are fundamentally different: clients often prefer small, frequent payments. This, coupled with the relatively small size of the premiums, poses a challenge to insurers. Partners, care providers, charitable insurers and community-based schemes are all likely to try to circumvent this by establishing a system where collection can be done either up-front, or through a deduction at source, or seek a third-party subsidy or advance.

However, the community-based model, the charitable insurer and agent organizations, with their access to clients, are naturally equipped to resolve this mismatch between the interests of the insurer and the insured. This is achieved by relying on existing social structures in the community and the existence of community workers who can piggyback on other interactions with the community. This makes it much easier for them to respond to requests for more frequent payment than it is for healthcare providers, which do not usually have regular contacts with the target market.

2.2 Product marketing: Trust and access required

An efficient sales process depends to a large extent on levels of trust and easy access to the clients as information exchange and client education make up the core activity in this process. The lack of a relationship of trust and access (both physical and psychological) to potential clients usually deters formal insurance companies from entering this market alone. This sits well with the philosophy behind the partner-agent model that the main responsibility for product manufacturing lies with the insurer, which then delegates distribution responsibilities to agents. From the clients' point of view, agents facilitate communities' access to insurers and providers which may otherwise be inaccessible to the clients, and provide the latter with access to a recognizable and trustworthy "brand".

In this regard, the marketing of the provider model can thus benefit from the professionalism of well-known hospitals. Many of the private hospitals associated with Yeshasvini Trust enjoy an excellent reputation. The Narayana Hrudayalaya hospital in Bangalore, for instance, is well reputed for cardiac surgery even beyond Karnataka state. The participation of hospitals like this is positively received by many insured members who otherwise would have difficulty accessing these quality care providers.

However, clients' trust in the organization that carries out the actual sales process is of even greater importance, and while insurance companies lack this relationship of trust, agents (in the form of local organizations like NGOs) usually have more respectability and thus ability to reach potential clients. Community-based schemes, as their name implies, are in constant contact with their members and are likely to have far greater levels of trust and access to them than many other organizations. As a result, the cost of informing members about the benefits of health insurance decreases, and the likelihood of a sale increases.

2.3 Product servicing: Managing the flow of information

On the whole, the interests of the different insurers are aligned in the servicing area. All would like an efficient system that would keep costs down and reduce fraud. A cashless system is usually best for achieving these goals, and has the added advantage for the insured of not having to advance money to get treatment. In the partner-agent and community-based model, a cashless system has the additional benefit of enabling the risk carrier to negotiate with healthcare suppliers to bring costs down. Not surprisingly, this negotiation does not take place in the provider-driven model, which effectively limits competition and could result in higher prices or lower service quality.

However, many insurance companies are unable or unwilling to negotiate and set up a relationship with a tight network of rural doctors or hospitals as they find it difficult to control the appropriateness of services rendered and claims filed. To obtain the information they require for verifying a claim without having to negotiate with an additional party (the provider), some insurance companies settle claims on a reimbursement basis only. This arrangement places a heavy burden on poor households. Due to complicated and inappropriate paper work, exclusions, and procedures required by the insurance companies, reimbursement is often delayed, sometimes for months.

Provider-driven insurers, community-based schemes and most charitable insurers are better placed in this respect. Due to their local presence, they can offer benefits in kind more easily – especially in a provider scheme. Their claim verification process is usually better adapted to local circumstances as well. This helps to keep clients satisfied and thus results in higher renewal rates and increased willingness to pay, and probably promotes equity.

2.4 Securing long-term sustainability

Just as the insured pay little attention to probabilities, they also tend to discount other technical aspects related to the provision of insurance, such as the need to pool risks (law of large numbers), the need to invest for the future, or the effects of a particularly high claim load in a current year on premiums (or even insurance availability altogether) for a future year. Nonetheless, the insured expect the insurance provider to meet all its liabilities and constantly reduce their losses.

This conflict poses considerable difficulties for all insurers, but it is a particular challenge for community-based schemes for two main reasons. Firstly, members are likely to exercise greater control over scheme decisions in a community-based model than in any other model. Therefore, in a year with relatively few claims, members might attempt to force the scheme to redistribute unused reserves or to increase benefits, which would pose a danger for long-term sustainability. Secondly, community-based schemes might not have the risk management expertise on hand, and are more likely to assess the actuarial risk incorrectly. While reinsurance can help resolve both of these problems, the fact remains that a stand-alone community-based model is likely to be most vulnerable as regards long-term sustainability (besides the charitable model which relies on indefinite subsidies).

To summarize, the basic incentive structures of the four models are captured in Table 45. In the last row of the table, the main conflicts of interest between different stakeholders are articulated for each model.

Table 45

Basic motivations and primary interest through the business process

	<i>Partner-agent</i>	<i>Charitable insurer</i>	<i>Provider</i>	<i>Community</i>
<i>Basic motivation</i>	Profit (for the insurer); coverage for the target group (for the agent)	Reduce the long-term cost of health risks for target group	Generate business and increase access to (own) services	Reduce the long-term cost of health risks for members
<i>Manufacturing</i>	Rare events that represent fewer, larger claims to keep transaction costs low	Responding to clients needs as well as possible	Benefit package designed with view on own services offered	Optimal balance between benefits and premium for the members
<i>Sales</i>	Use of agents (e.g. MFIs) to enhance proximity and ease of payment	Use of existing community structures (e.g. SHG, NGOs, etc.) to keep costs low	Distribute among potential patients as long as number can be serviced in facility	Use of existing community structures (e.g. woman's associations) and involvement of members
<i>Servicing</i>	Reduce fraud (e.g. with cashless systems) and negotiate on scale with supplier to drive down costs	Reduce fraud (e.g. with cashless systems) and negotiate on scale with supplier to drive down costs	Reduce fraud (e.g. with cashless systems) and negotiate on scale with supplier to drive down costs	Reduce fraud (e.g. with cashless systems) and negotiate on scale with supplier to drive down costs
<i>Sustainability</i>	Price products correctly, achieve a sufficiently large group size and risk diversification, while maintaining high renewal rates	Price products correctly, achieve a sufficiently large group size and risk diversification, while keeping high renewal rates	Achieve high renewal rates, sustain desired client group for services that have excess capacity	Price products correctly, achieve a sufficiently large group size and risk diversification, while maintaining high renewal rates; prevent members from divesting reserves from future years

	<i>Partner-agent</i>	<i>Charitable insurer</i>	<i>Provider</i>	<i>Community</i>
<i>Main conflicts of interest</i>	<p>Insurer-agent: Agents usually regard themselves as advocates of the insured rather than the insurer, though their financial incentives are aligned with those of the insurer</p> <p>Client-insurer: Feel that money is lost to a big and distant company if not claimed at least once a year</p> <p>Insurer-client: Profit motive of the insurer might drive the premiums up</p> <p>Insurer-client: Investor-owned risk capital in microinsurance results in high expectations of return on the part of the shareholder</p>	<p>Insurer-client: The paternalistic and social characteristics of the charitable model might favour health objectives of donors/NGO management over clients' preferences</p> <p>Insurer-client: Where dependent on donor funding, it may not reduce the real long-term cost of risk for the client</p> <p>Client-insurer: Expect services to be provided regardless of whether their cost is sustainable or not</p>	<p>Insurer-client: Interest in good utilization of facility and thus includes (only) own services in the benefit package. This might result in benefit packages being too narrow for effective risk protection for target group</p>	<p>Manager-members: Tempting for managers to enlarge the insurance scheme, but this often does not benefit the members. With growing size of the insurance scheme, managers tend to lose focus on the members and members rarely have the skills to control them effectively</p> <p>Field staff-insured: Field staff are usually taken from the group of insured; social inequalities within the group of insured might lead to unequal treatment of insureds. Some might be persuaded not to use services for the sake of stability of the entire scheme</p>

3

Conclusion

This chapter reviews a basic typology of health microinsurance providers based on an examination of their primary motives and underlying business processes. One interesting issue can be highlighted by asking a simple question: whose interest is served if an insured (client) claims benefits? Obviously, the individual claiming can be assumed to gain, but what about the different insurance providers?

It can be argued that charitable organizations, and to an extent provider-driven organizations, would see a utilization of health services as a positive outcome. However, under the partner-agent model, the partner would have an incentive to discourage claims (ideally through good health, although complex claim requirements could be an alternative). Indeed, in schemes where insureds only receive benefits if they are sick (or rather, when they claim successfully), the incentive structure could be seen as encouraging false or unnecessary claims. The partner-agent is the primary example of this incentive conflict, and this additional risk therefore needs to be considered when designing business processes.

Other models would also, from an insurance business perspective, prefer to have fewer individuals claiming, but (and this is an important nuance) the primary focus would be on the good health of the clients, at least in theory. In practice, in community-based schemes, more powerful members may try to exert influence on the benefit package design or try to persuade other members not to claim in order to keep claim costs low. Inequalities in the social structure of communities have to be closely examined and taken into account.

Another important point is whether the scheme operates under a for-profit or non-profit paradigm. In the provider-driven model, for example, if the hospital is running a for-profit scheme, then it would share many of the characteristics of the partner-agent model and would have an interest in fewer claims and more profits. However, if the provider is running a non-profit insurance scheme, whereby surpluses remain within the scheme, then it would have an interest in increasing utilization, which would in turn increase consumption of its own health services (and thereby its “profitability”), up to a certain level of utilization. Once demand for services exceeds the provider’s capacity, it would also have an incentive to reduce consumption, usually through a long waiting period for insured events (which may be shortened or eliminated in cases where the insured is willing to pay extra for the service).

The community-based model reverses this incentive structure by keeping the unclaimed sums at the disposal of the group. Furthermore, through judicious use of social capital (particularly through peer monitoring in member selection and claims processing), the community-based model reduces adverse selection and moral hazard – but only if it is truly participatory and members take over ownership. Therefore, if its long-term sustainability can be assured, it seems that the community-based model has a number of advantages in health microinsurance provision, as it has better information on (and contact with) its clients, far less scope for conflicts of interest, and better mechanisms to mitigate adverse selection and moral hazard.

It would be naive to assume that one model combines all advantages and no disadvantages. All models need to learn from each other to achieve an optimal business process. The partner-agent-model, for instance, is strengthened considerably when it integrates features of the community-based scheme, such as involving the target group in designing the benefit package, or introducing a profit-sharing arrangement in good years. In a similar vein, the community-based model can learn from professional insurers, notably on how to resolve technical and sustainability problems (including access to reinsurance, which would not only add to financial stability, but can help in acquiring the technical resources necessary for running a viable business).

Health microinsurance is a different animal from insurance for the formal sector, and what works well for high-net-worth clients is not easily replicable for informal and rural communities. While health microinsurance holds much promise, the question of appropriate institutional options and channels for its delivery will need to be looked at closely by academics and practitioners. If this question is overlooked, then the very concept of health microinsurance could be tainted as inefficient due to inadequate provision models.

Beyond MFIs and community-based models: Institutional alternatives

Richard Leftley and James Roth¹

The authors wish to thank Vijay Athreya (Tata-AIG), Doubell Chamberlain (Genesis) and Jeremy Leach (FinMark Trust) for their useful comments and suggestions.

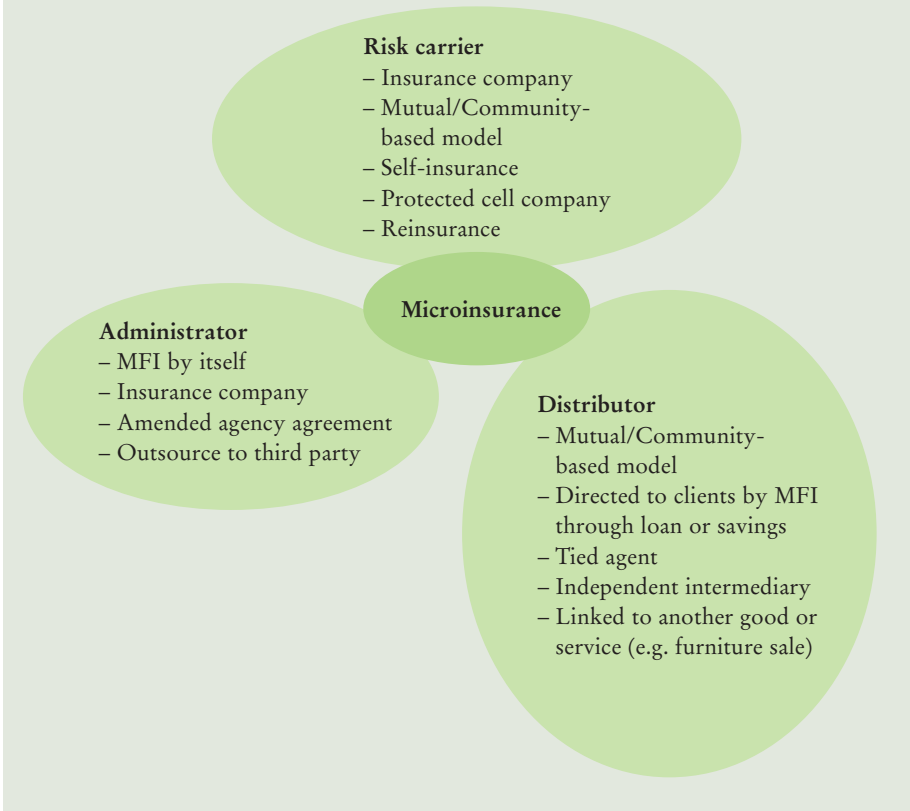
For the most part, insurance for the low-income market is a high-volume, low-premium business. There are instances where microinsurance clients are more concerned about quality than price, for example funeral insurance in South Africa, but on the whole the low-income market is deeply price-sensitive. Keeping costs low is therefore a necessary requirement to attract customers and make the business sustainable.

As discussed in the previous chapters, in many circumstances the partner-agent, the cooperative or the community-based models will provide suitable solutions. The partner-agent and co-op models build on established distribution networks (e.g. an MFI or credit union) that already provide financial services to the poor, so insurance is simply added to an existing channel for a marginal cost. With the community-based model, which is managed by the policyholders themselves, costs are minimized by the reliance on volunteer labour and leveraging social capital to control insurance risks. These are not, however, the only microinsurance models.

This chapter explores other institutional options for the provision of insurance to the poor. In an insurance structure, someone has to 1) carry the risk, 2) administer the product and 3) handle the distribution (*see Figure 3.1*). These functions could all be performed by one organization (e.g. the direct sales approach at Delta Life in Bangladesh), or they each could be managed by different organizations, or some combination of the above. By using this framework to break provision down into three definable segments – risk carrier, administrator and distributor – this chapter considers the range of alternative arrangements for providing microinsurance. The chapter looks at where the various options are appropriate and how they would decrease cost and/or enhance the product quality.

¹ References to the Micro Insurance Agency are drawn from the authors' experiences.

Figure 3.1

Three components of insurance provision²**I Risk-carrying alternatives**

While most risk carriers are regulated insurance companies, there are alternative ways of underwriting risk. This section considers both self-insurance and protected cell companies.

I.1 Self-insurance³

Perhaps the most commonly considered alternative for carrying risk is self-insuring, where an unlicensed and unregulated organization offers its own insurance product. This option is employed by TYM (Viet Nam), MUSCCO (Malawi), AssEF (Benin) and Spandana (India); many other organizations

² The authors wish to thank Jeremy Leach for providing them with this framework.

³ The term “self-insurance” is used differently in this chapter from in Chapter 1.2. In Chapter 1.2, self-insurance refers to ways in which low-income households cope with losses by carrying the risk themselves, for example by covering the costs from savings or liquidating assets. In this chapter, and in Chapter 4.7, the concept of self-insurance is applied at an institution level – that is informal, unregulated insurance schemes that carry the risks for their members.

have tried self-insurance, but have ultimately reverted to the partner-agent approach, including SEWA and ASA in India.

Self-insurance is often outside the legal framework. While many insurance supervisors are willing to look the other way, the schemes usually operate in a grey area, vulnerable to political changes. Most self-insurers do not have access to the actuarial expertise required to calculate premiums or reserves. As unregulated insurers, these organizations are unable to purchase reinsurance to reduce their potential losses in the event of catastrophes. Indeed, as discussed in Chapter 4.7, if organizations want to self-insure, one of the preconditions will be some way of dealing with covariant risks other than just excluding them.

Self-insuring organizations often offer poorly priced products that either provide poor value for money to clients or lose money for the organization selling it. Organizations that do manage to calculate a rate that generates a profit are often unable to avoid the temptation of raiding the pot at the end of the financial year. The result is that no reserve is built up for “incurred but not reported” (IBNR) losses or to cover potential future losses arising from catastrophes, such as natural disasters or disease epidemics.

Reserves are particularly important for organizations that are unable to secure reinsurance. Even if reinsurance is available to an informal self-insurer, reserves are still needed because reinsurers will not offer coverage that guarantees a breakeven or profit. If the reinsurance is placed on a proportional basis (e.g. quota share or surplus treaty), then the treaty will be arranged so as to leave the primary risk carrier with some retained risk; otherwise a moral hazard problem arises whereby the primary insurer has no motivation to ensure the quality of the business or validity of claims. If the reinsurance is placed on a non-proportional basis (e.g. excess of loss treaty), then reserves will be required to cover the retention as well as the losses that exceed the treaty (*see Chapter 5.4 for more details on reinsurance*).⁴

1.2 Protected cell company

The self-insuring option has some significant limitations; but there will be instances where a required product is simply not available from a regulated risk carrier. In cases where a microinsurance product is not available, the pricing is disadvantageous for the client, or the required level of customer

⁴ An excess of loss treaty can be exceeded in two ways: 1) vertically, whereby the accumulated loss exceeds the value of the cover that would be purchased on the basis of the “probable maximum loss” or PML, or 2) from a series of losses that exceed the sideways cover afforded by the limited reinstatements of the lower layers of the programme.

service is deemed to be lower than what the market expects, then a protected cell company (PCC) could be a viable option.

A PCC transacts insurance using the host insurance company's capital and regulatory status. Policies are issued in the name of the insurance company. The contract drawn up between the host insurance company and the PCC's owner stipulates, among other things, that a management fee will be paid to the host by the owner as a "rental" for the licence required to transact insurance.

The PCC's owner is entitled to determine the terms and conditions of the insurance products that are provided to its clients. The owner can determine the pricing of any product as well as the service standard, for example the speed of claims payment. At the end of the year, any profit or loss is the responsibility of the owner. If the products are incorrectly priced then the protected cell company would end up having to fund the loss. In most cases, the host would help the owner to purchase stop-loss reinsurance so as to limit the financial cost of any underwriting loss.

To date there has been very limited evidence of microinsurers using PCCs as a method of carrying risk (*see Box 81 for an example of an aborted attempt*).

Box 81

Zambuko Trust, Zimbabwe

In April 2003, Zambuko Trust, a microfinance NGO in Zimbabwe, was seeking to develop a funeral insurance product with technical assistance from Opportunity International. The customer-needs analysis showed that clients expected claims to be paid within 24 hours. This requirement had arisen because many clients participate in informal burial societies, which often pay claims within hours.

While a range of regulated insurance companies were willing to provide a suitable funeral product for Zambuko's clients; none of them could pay claims so quickly. The management of Zambuko believed that in order to compete with informal providers, claims payment within 24 hours was an essential product feature. The only alternative was to seek to gain control over the product and hence the service provided to clients.

After some negotiation, one insurance company was willing to host a "protected cell company" owned and managed by Zambuko Trust. Ultimately, however, the management of Zambuko decided that due to the economic situation and rapid inflation in Zimbabwe, pricing of the insurance products would be difficult and the risks associated with the venture were too high, so the initiative never got off the ground.

Source: Adapted from Leftley, 2005.

The protective cell company is essentially a legal way of self-insuring. By writing policies on an insurer's licence, it is also possible to tap into the expertise of a friendly insurance company that may assist in establishing reinsurance cover. Like self-insurance, the most significant downside is that any underwriting loss must be funded by the PCC's owner. In addition, the owner must have access to insurance expertise on a regular basis to manage the PCC and establish suitable products and rates. Another disadvantage is that it may be difficult to set up unless the owner has a close and trusting relationship with a prospective host. Furthermore, if the product to be sold is already available from the insurance company then there will be little incentive for it to offer a PCC structure as it would be more profitable for the insurance company to utilize the owner as a distribution channel and carry the risk itself (i.e. the partner-agent model).

2 Administrative alternatives

Typically the work load associated with the administration of insurance products can be broken down into two key stages: firstly, there is policy formation, where the client completes an application form and pays a premium and secondly, there is a claims process where details of a loss need to be recorded and the benefit paid to the claimant.

The procedures relating to premium collection (*Chapter 3.3*) and claims administration (*Chapter 3.4*) are covered elsewhere in this book; this section considers two alternatives for conducting this administration: amended agency agreements and third-party administrators. By way of comparison, it is broadly true that for those operating according to the partner-agent model, policy formation and premium collection are carried out by the agent (such as an MFI), and the claims administration is performed jointly, with the agent collecting the claims documentation and the partner (insurance carrier) verifying and paying the claim.

2.1 Amended agency agreements

A crucial element of an insurance product for a low-income policyholder is the speed at which claims are paid. In the partner-agent model, while the agent may inform clients about the involvement of an insurance company, it is quite common for clients to blame the agent's field staff when claims are delayed. Even when insurance companies take steps to reduce the waiting times for claims payment, it often takes a few weeks to process a claim. When this processing time is added to the time that it can take for a client to gather

the required claims documentation and for the MFI to perform its own administration, months may pass from the occurrence of the insured event to the claims settlement.

In many organizations, this delay has caused considerable client dissatisfaction. To overcome the problem, several MFI agents have sought to amend their agency agreements so that they assume responsibility for managing claims. While this is a modification to the standard partner-agent model and not an institutional alternative, it is worthy of mention as it shifts key tasks, namely verifying and paying claims, from the insurer to the MFI.

For example, CETZAM pioneered funeral microinsurance in Zambia by collaborating with NICO Insurance in 2001 to provide the Ntula Funeral Insurance product. By May 2002, it was clear from market research that claims payments were taking too long, and as a result NICO was asked to consider amending the agency agreement.

It was agreed that CETZAM would pay the claims it considered to be valid. The documents that supported the claims would be submitted along with the monthly premium report and premium payment (net claims paid) and NICO would check the documents to ensure that they agreed with the claims that had been paid. If CETZAM paid an unjustified claim, then NICO would demand repayment of the claim value; to date no claims have been refuted by NICO. The claims settlement period fell from two months to less than two weeks as a result of this agreement.

An amended agency agreement is a way to improve the partner-agent model. It is particularly appropriate for life insurance, since the applicable insured event is easy to verify and hard to fake. For other risks, additional training may be required for the agent's field staff to know how to verify claims. For example, staff will have to learn how to distinguish between accidental and natural deaths if they result in different benefits. In India, VimoSEWA has developed such expertise in verifying claims that its insurance partners allow it to pay health and property claims (*see Box 82*).

Box 82

VimoSEWA's claims committee

During a period when VimoSEWA managed its own insurance fund, the organization brought in an insurance claims expert to establish protocols, form a claims committee and train staff. When VimoSEWA reverted back to the partner-agent model in 2002, it negotiated with its insurance partners to allow it to continue paying claims.

VimoSEWA has an eight-person claims committee, consisting of head office staff, insurance field agents (*Vimo Aagewans*) and field workers (*Aagewans*) from SEWA's health, union, childcare and bank teams. The committee meets three times a week and a doctor attends the committee if there are complicated health claims. He also assists the committee by imparting information on diseases and medical terms.

Representation of various *Aagewans* is essential for fair claim settlement practice. It helps the committee gain knowledge on insurance practices, and they carry the message of unbiased claim settlement to their members and teams. Occasionally, the insurers reject a claim that the committee feels should be paid, but VimoSEWA assumes the liability for these extra-contractual claims. The claims committee plays an important role in detecting fraud and moral hazard. The physician is particularly helpful in assessing which caregivers are providing expensive or unnecessary treatment.

Source: Adapted from Garand, 2005.

2.2 Outsourcing to TPAs

It is common practice for insurance companies, particularly those involved in health insurance, to outsource the administrative work to a third-party administrator (TPA). There are, however, few instances of this outsourcing among microinsurance schemes, largely because simple products like credit life are relatively easy and cheap to administer, so they rarely motivate management to consider the costs and benefits of outsourcing some or all of the administration.

For health insurance, the case for outsourcing needs to be assessed. Health insurance typically involves a relationship with a health service provider. This relationship, among other factors, introduces costs and new administrative burdens, such as ensuring that the health provider is not defrauding the scheme. Health insurance schemes often outsource part of their administrative operations to a professional TPA. By specializing, TPAs are often able to lower the overall administrative costs.

Third-party administrators are fairly common in South Africa where local insurance companies use them to administer funeral insurance – indeed some administrators have developed such large client bases that they themselves have become insurance companies. The TPAs purchase insurance cover in bulk from the insurance company and retail it to individual clients or groups of clients at a price that may be much higher than the price they paid to the insurance company (though it should be noted that the administrators are often able to provide access at a lower price than that charged by insurers through their normal distribution channels). The policies are issued

in the name of the insurance company. The TPA is authorized to verify and pay all claims on behalf of the insurance company without supervision from the insurance company, which can lead to extremes of either fraud or refusal to pay claims. As a result, a section of the TPA market in South Africa has an increasingly tarnished image with consumers, the insurance companies and regulators.

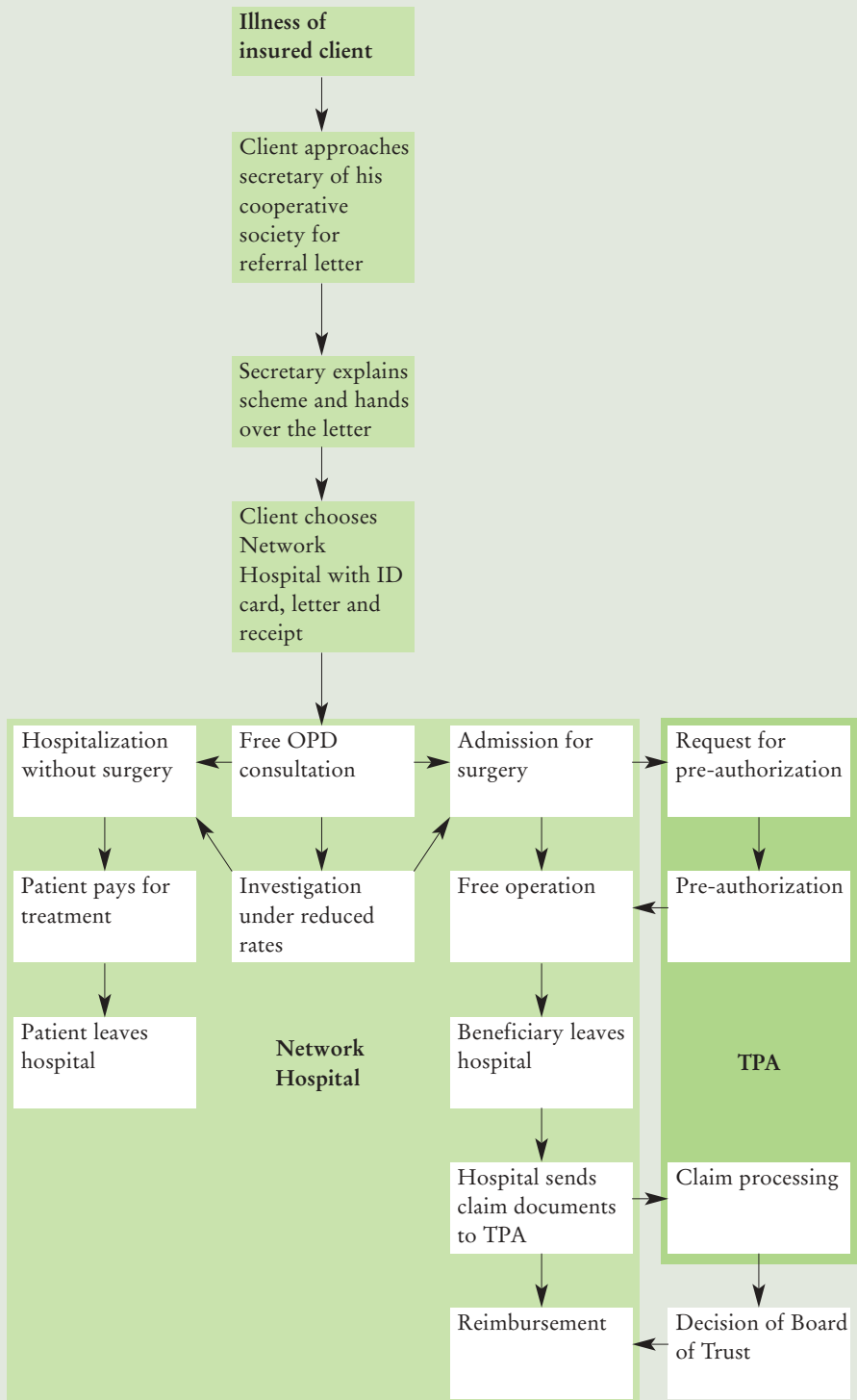
Yeshasvini Trust, a health microinsurance scheme in India, decided to outsource its administrative functions to a TPA. The Yeshasvini Trust offers insurance to cover high-cost, low-frequency surgery for as little as Rs. 120 (US\$2.70) per year for a maximum cover (per person per year) of Rs. 200,000 (US\$4,545). To help the scheme manage its 1.45 million members, Yeshasvini developed a relationship with a private TPA, the Family Health Plan Limited (FHPL), which also administers insurance schemes for the police in the southern states of Karnataka and Andhra Pradesh. The TPA assumes the following tasks:

- Maintaining a register of the insured clients
- Authorizing treatment
- Issuing ID cards to members
- Preparation of claim settlement including verification
- Preparing reports and statistics
- Managing the funds

FHPL plays a critical role as the gate-keeper for approving surgery and then paying the hospital, so policyholders requiring surgery have no out-of-pocket healthcare expenses (*see Figure 32*). This arrangement is not without difficulties. While outsourcing can increase efficiency, the addition of an extra institution can also add complexity. Sometimes it takes FHPL four or five days to authorize surgery, and occasionally reimbursements to the healthcare providers are also delayed. In general, however, the arrangement of having specialized agencies focusing on their areas of expertise makes sense, especially when dealing with such huge volumes of policyholders accessing services from more than 150 healthcare facilities.

Figure 32

Yeshasvini's claim settlement process



Source: Radermacher et al., 2005b.

In terms of the costs, FHPL and Yeshasvini Trust negotiated payment of Rs. 7 million (US\$159,000) in Year 1 and Rs. 4 million (US\$90,900) in Years 2 and 3. Since these fees are equivalent to 2 to 3 per cent of premiums over the past two years, this seems like a very affordable solution for Yeshasvini. According to Radermacher et al. (2005b), FHPL claims to implement the scheme on a non-profit basis because it provides it with experience in serving the market at “the bottom of the pyramid”.

3

Distribution alternatives

Many clients who currently purchase microinsurance have gained access through financial organizations with which they have an existing loan or savings account. Even though this institutional arrangement has significantly reduced the transaction costs associated with providing insurance, it has limitations because clients can only gain access to insurance when they have an active loan or a savings account.

In principal, there are a multitude of options that could be used to distribute insurance products to low-income households, including:

- *Retailers* – for example supermarkets that collect premiums at the checkout counter
- *Workers’ unions and cooperatives* – premiums could be deducted from dues
- *TV/direct sales* – advertise products directly to the customer with telephone operators standing by
- *Cell phones* – using the cell phone infrastructure to gather premium payments
- *Burial societies and ROSCAs* – use the informal societies to sell a regulated product
- *Worksite marketers* – sell products to low-income workers during lunch breaks

While these channels may work in developed countries, many developing countries do not have sufficient infrastructure or levels of client education to implement such distribution methods. So what alternative forms of distribution have been used to deliver microinsurance? Besides partnerships with retailers, which are discussed in detail in the next chapter, this chapter considers the role of microinsurance agents and independent microinsurance intermediaries.

3.1

Microinsurance agents

Tata-AIG in India has developed a system of micro-agents to deliver term and endowment policies to the low-income market. In this model, the insurer identifies NGOs that have a good relationship with the community and develops partnerships with them. In return for a consulting fee, the NGOs suggest persons who could be good agents to sell microinsurance policies: the micro-agents. If these recommended micro-agents are accepted, they are then asked to form groups of peers.

The group, referred to in the Tata-AIG model as a Community Rural Insurance Group (CRIG), consists of five low-income women living in close proximity, of whom the leader is licensed as an agent. The CRIG is registered as a partnership firm. The CRIG members are typically women because they tend to work with, and come from, self-help groups (SHGs) whose members are usually women. While not the only target market, the SHGs represent an easy way to reach large numbers of potential policyholders because the members are already accessing financial services and making regular payments.

Tata-AIG helps the group leader obtain an agent's licence, which requires an investment in training the individual. Thereafter the CRIG, as a statutory enterprise, obtains a corporate agent's licence under the insurance regulator's guidelines. The members of the group all sell policies for their own account, but the leader with the agent's licence fills in the forms and submits the policies to the company under the guidance of the NGO. In return for this task, the NGO receives an additional commission percentage from Tata-AIG.

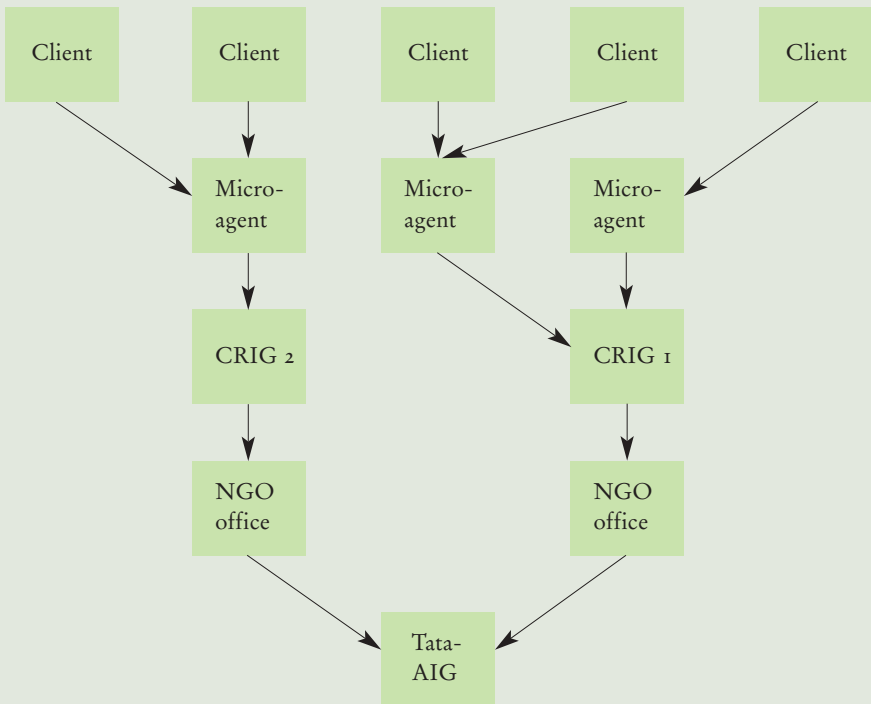
In addition to the group approach, where getting five like-minded, somewhat educated women to start a firm can be difficult, Tata-AIG uses individual micro-agents. Like the CRIGs, individual micro-agents tend to be women (though some are also men) who are either involved in an SHG or voluntary workers of an NGO. After being certified, micro-agents are encouraged to acquire clients in the vicinity of their homes, which may extend to surrounding villages.

The advantage of a CRIG over individual micro-agents is that only one in five agents needs to be licensed, which lowers start-up costs. The group can also structure responsibilities in ways that suit the expertise of the individuals; for example, some people may be better at selling and others may be better at collecting premiums. If a CRIG member is sick or travelling, or chooses to stop working as an agent, other CRIG members can fill in accordingly. This leads to better management of orphaned policies. In the long run, once fully functional, the CRIG can also be linked to other marketing organizations to distribute non-competing products and services and enhance their income.

In this model, the NGO carries out a variety of tasks including aggregating premiums and sending them on to Tata-AIG (see Figure 33), allowing the agents to use their offices to conduct business, playing a role in the training of micro-agents and helping in the assembly of claim documentation and the distribution of claim benefits. The model thus has an additional positive spin-off in that it provides a new income stream for rural NGOs and micro-agents.

Figure 33

Micro-agents, CRIGs and NGOs in the premium-collection process



Source: Roth and Athreya, 2005.

This distribution method is similar to the direct-marketing model of firms such as Tupperware and Avon, where salespersons work on a part-time or occasional basis selling to their family, friends and neighbours. For the agents, this type of work is particularly appropriate as a supplementary income source. Generally, the CRIG commission per policy is 26 to 30 per cent of the premium for the first year, and between 5.5 and 6 per cent for the second and third years. From the fourth year onwards commissions vary between 4 and 5 per cent.

Tata-AIG has not assessed what percentage of the micro-agents' livelihood is provided by their insurance work, although the monthly income earned by CRIG members ranges from Rs. 55 (US\$1.20) to Rs. 2,487 (US\$55.26), with an average of Rs. 665 (US\$14.78). It is estimated that micro-agents could earn at least US\$15 per month over 15 years, if they sell 250 policies in 2 years, and then service the policies for the full term of 15 years. The earnings are larger in the first two years because the commissions are front-loaded. However, in the third year micro-agents are trained to enhance their incomes by focusing on sales of higher premium products, so they could earn significantly more than US\$15 per month if they succeed with the wealthier market.

Even though the insurer does not incur any fixed costs (e.g. salaries and benefits) for its agents, the micro-agent model can still be an expensive way to deliver insurance. The cost of training and supporting agents is quite high in relation to the premium values. Although initial transaction costs are low for the agents, after they have sold policies to all the people they know and need to sell to strangers, it can become much more expensive and difficult, especially to reach people living far away.

3.2 Independent microinsurance intermediaries

Unlike Tata-AIG's microinsurance agents, there is an increasing role for microinsurance intermediaries that are independent of a single insurance company. An independent intermediary could be a corporate or individual partnership structure, working on either a local or global scale, that collaborates with a risk carrier (probably an insurance company).

While the agents discussed above work on behalf of a single insurance company, a broker works for multiple insurers. To reach the low-income market, the broker seeks to service large groups of clients through aggregators. The most suitable aggregators of low-income persons have an existing financial structure such as MFIs, rural banks and credit unions. However, groupings such as cooperatives, unions and even religious organizations, can also be targeted. The benefits of the intermediary are as follows:

1. Product development

Existing partner-agent models often place the product design in the hands of the risk carrier, which is not ideal. An intermediary that understands the needs of clients, the operational realities of the aggregator and the needs of the insurance company should be able to design a product that is more suitable for all parties.

2. Transaction costs

It is not cost-effective for an individual aggregator to develop its own MIS for transacting insurance business. An intermediary with a wider client base benefits from economies of scale which justify such an overhead. Investment in systems reduces transaction costs and increases operating efficiency by serving a much larger client base than a single aggregator can reach.

3. Administration

An intermediary is well-placed to handle administration relating to claims processing as well as reporting to the insurance company who is covered and the premiums due.

4. Additional channels of sale

Aggregators are often unable to offer insurance to persons who are not using their credit services. An intermediary brings the capability to track clients and record the premiums paid, even when a loan is not in place.

5. Staff training

An intermediary is well placed to provide organizations' staff with the required training. This increases financial literacy and, ultimately, client satisfaction.

In November 2005, Opportunity International established such an intermediary, the Micro Insurance Agency. Its first subsidiary was opened in Uganda in January 2006 to work as an intermediary for Microcare Insurance Company. Its initial product range has been targeted at the microfinance institutions and is based around a package of credit life, funeral, disability and property coverage. There are plans to introduce healthcare products later in 2006 as well as subsidiaries in Ghana, South Africa and the Philippines.

Besides targeting microfinance clients, the Micro Insurance Agency plans to sell products to client groups served by unions, cooperatives and religious organizations. To reduce transaction costs, Opportunity International has developed its own AIMS software (Automated Insurance Management System).

4

Conclusions

There are three essential institutional elements for insurance provision: risk carrier, administrator and distributor. Within each of these categories, multiple options could be used to serve low-income communities. By thinking outside the industry's current collective experience, it should be possible to combine the options into new and innovative ways of providing microinsurance. In addition, by being flexible with the tasks of different entities, it should be possible to reduce transaction costs and provide better products.

Clearly the options in the risk-carrier category are restricted and in the majority of cases utilizing a registered insurance company will remain the most likely outcome. MFIs seem to face increasing levels of regulation brought about by heightened government interest in the sector. This regulatory burden makes self-insurance more difficult and unwise; no microfinance bank wants to face closure as a result of breaching local insurance regulations. The remaining potential risk-carrying alternative is the protected cell company, yet PCCs are rare outside South Africa and Brazil. Perhaps donors and industry practitioners should investigate further the reasons for this and the potential for developing the protected cell as a risk-carrying alternative.

To date, the majority of microinsurance has been distributed and administered by MFIs. While these organizations provide the necessary scale to make insurance sustainable, the breadth and depth of products that can realistically be provided via MFIs is limited. If microinsurance is to achieve its full potential, then it needs to diversify distribution and administration to include other organizations that engage in financial transactions with the low-income market. Certainly, amended agency agreements are important in providing higher levels of customer service (e.g. speed of claims payment), but other administrative options should be explored in the future. For example, third-party administrators have demonstrated that they can significantly decrease transaction costs across all lines of business.

Of course, the major factor affecting the distribution and administration of microinsurance products is the small margins which can be earned. With premiums in the range of a few dollars, the remuneration received by a TPA or an insurance intermediary per policy is extremely small. This is a major reason for the lack of microinsurance agents. To significantly scale up the low-income market's access to insurance, there is a strong case for donors teaming up with industry pioneers to find new ways to distribute and administer products, which will lead to a wider range of products being available to more low-income people.

James Roth and Doubell Chamberlain¹

The authors appreciate the insights and suggestions provided by Vijay Athreya (Tata-AIG), Jeremy Leach (FinMark Trust) and Marc Nabeth (consultant).

While much of the microinsurance discussion has focused on MFIs or cooperatives as distributors of microinsurance, some insurers have begun to explore new distribution channels to reach the low-income market. Many are turning their attention to retailers, companies that sell goods and services other than financial services to poor households. They include grocery stores, household goods shops, transport providers, funeral parlours, cell phone shops, post offices, petrol stations, agricultural input suppliers and estate agents selling low-cost housing. In some cases, the process is being led by retailers who want to add additional services to their product lines; in other cases, insurers (often compelled by legislation or more subtly persuaded by the state) are looking at ways to reach the poor.

This chapter begins by considering the preconditions that need to be in place, for the insurer and the retailer, for this model to be effective. It then considers the types of microinsurance distribution model/products combinations that have been offered by retailers, largely based on the experiences in South Africa. The experiences suggest that for particular products, retailers could be an effective distribution channel for the low-income market, but current models still face challenges in unlocking this potential.

I Why retailers? Which retailers?

There are a variety of reasons why the distribution of microinsurance products through retailers is of interest. Retailers often have a more extensive distribution network than that of dedicated financial service providers. They can reach a larger market. People not interested in savings or loans may be interested in buying food, fertilizer or furniture. By (potentially) reaching a

¹ This chapter is based largely on the results of a consulting report commissioned by the FinMark Trust (Chamberlain et al., 2006). South African examples without citations are drawn from that source. Rand/Dollar conversions are based on the average exchange rate for December 2005 (R6.35 = US\$1).

larger market, this network can distribute products at a lower (shared) cost than dedicated financial service providers. Many retailers have established a visible and trusted presence among lower-income households, creating an opportunity for distributing other, possibly more complex, products such as insurance, for which trust is essential.

Evidence from models developing across the globe suggests that participating retailers and the insurance companies have to have a number of characteristics for retailer distribution to be successful:

- Retailers need to have **regular transactions with low-income persons** so that premium collection can be layered on top of an existing transaction. This requirement assumes that low-income persons are unlikely to make a special trip just to pay the premium.
- They need to have sufficiently sophisticated **financial systems**² to account for premiums. While some retailers, especially chains such as supermarkets and petrol stations, may have adequate systems, informal retailers may struggle to account effectively.
- As microinsurance is a low-premium, high-volume business, a single retailer needs to be able to access a **sufficient number of potential clients**. Volume is needed to achieve economies of scale that can justify the start-up and administrative costs for the insurer. Consequently, it is advantageous for insurers to collaborate with a network of retailers rather than having to deal with individual stores. This tends to preclude the use of small informal stores unless the insurance is paid for in advance by the retailer, by being bundled with either the product sold or some other form of pre-paid insurance (as described in Section 2 below).
- In all insurance products, there needs to be **trust** in the benefits actually being paid. This is particularly important for microinsurance, as poor policyholders are unlikely to challenge the insurer through the courts and may not be sufficiently financially literate to understand the terms of the policy. Owing to the low insurance usage in many developing countries, low-income people are often unaware of the names of insurers. For example, in South Africa in 2005, a survey of brands conducted by a market research company found very limited recognition of insurance brands (fewer than 1 in 10 low-income consumers could name an insurance company), but extraordinarily high brand recognition of clothing and furniture retailers. A similar scenario exists in India where, as described in Chapter 3.2, clients of Tata-

² In South Africa many retailers have a long history of providing credit to low-income consumers, thus building up the financial services competence of their staff. This is not a necessary condition for retailers to distribute microinsurance, but has undoubtedly helped.

AIG were on the whole aware of the Tata group and trusted it, but had not heard of one of the world's largest insurers.

- Insurers need to have **mechanisms to monitor the performance** of the retailer, and be able to legally compel it to hand over premiums without defrauding them. While it is possible to introduce controls as a deterrent against such fraud, they can be costly, especially in relation to the premium amount.
- It goes without saying that the **retailer must have incentives** to carry out its role, but it is not always as simple as just paying a commission. When retailers sell goods together with insurance on those goods, there is a clear convergence of the retailer's and insurer's interests. In some cases, however, there may be a conflict of interest. Very poor clients paying an insurance premium may purchase less of whatever the retailer is selling.
- Finally, as mentioned in Chapter 3.4, in microinsurance it is particularly important to **provide benefits quickly** in a way that is accessible to the policyholder. This may require empowering the retailers to settle claims before being reimbursed by the insurer. However, not all retailers will be in a position to do this.

2 Microinsurance distribution/product combinations for retailers

There are four primary ways in which microinsurance can be sold through retailers:

1. Bundled insurance linked to the product sold
2. Bundled insurance unrelated to the product sold
3. Voluntary insurance linked to the product sold
4. Voluntary insurance unrelated to the product sold

The most common is to bundle insurance with another product. When the product is purchased, the insurance is automatically purchased. With some bundles, there is a direct link between the product and the insurance; however, with other bundles, this is not the case. The same applies to voluntary insurance products.

2.1 Bundled insurance linked to the product sold

An example of bundled insurance that is linked to the product sold by the retailer comes from a South African furniture group (Ellerine Holdings)³

³ Ellerine Holdings is one of the largest credit retailers of furniture in South Africa. While the Ellerines policy is used for the purposes of illustration, the general findings are applicable to all furniture retailers retailing insurance. For more details on other credit retailers see Chamberlain et al., 2006.

with 1,220 stores across the country. The stores are mostly targeted at lower-income consumers and sell household goods (mostly furniture and electronic items). Insurance policies are bundled when goods are sold on hire purchase (a rent-to-own leasing agreement). A typical Ellerines policy contains four main types of cover:

- **Asset insurance** provides for replacement or repair of a purchased item if it is damaged, lost or stolen. At the discretion of the insurer, the policyholder can also receive cash compensation.
- **Loan insurance** provides for the full repayment of the outstanding balance of the loan to the retailer if the policyholder dies, is injured and/or becomes unemployed.
- **Life insurance** provides a fixed funeral benefit of US\$472 (R3,000) in the event of the death of the policyholder (i.e. does not cover family of policyholder). Any outstanding debt is deducted from the funeral benefit and the remainder is paid to the beneficiaries. An additional benefit of US\$1,575 (R10,000) is paid in the case of accidental death. The full amount is paid to the beneficiaries and no deductions are made to cover outstanding debt.
- **Health insurance** provides antiretroviral treatment (for the period of the credit agreement) if the policyholder is accidentally exposed to the HIV/AIDS virus.

In South Africa, as in many countries, the purchaser/lessee is not compelled to take the retailer's insurance. In practice though, few borrowers are aware of this right.

Claims are lodged with the insurer and the payment, except for life and health insurance, is made to the relevant store. All policy administration and claims management are handled by the relevant insurance company (in the case of Ellerine Holdings, the insurer is a member of the retailer group).

The four types of coverage contained in the policy overlap in a variety of ways, limiting the liability of the insurer and, by extension, the policyholder's ultimate cover. Overlap, for example, occurs if a policyholder's death is non-accidental. In this scenario, the outstanding balance on the policyholder's account will be covered by the life insurance if the outstanding loan balance is less than the sum insured. If the outstanding debt, however, is greater than the defined funeral benefit, the excess of the debt over the defined funeral benefit will be covered by the loan insurance. For the coverage to be in force, the policyholder must not have fallen behind with monthly instalments.

The retailer's management indicated that 95 per cent of all customers purchasing products on hire also buy *its* insurance product.⁴ In the 2004/05 financial year, only 6,400 claims emanated from its 500,000 credit-consumer base. Thus, for every 100 individuals that actually bought the policy at the retailer's stores, only 1.28 claims were filed. This claims ratio could be interpreted as indicating that customers do not experience the contingencies covered by the policy. However, in the South African context of employment instability, high crime rates and high mortality due to HIV/AIDS, this is unlikely. The low claims ratio more probably indicates that few customers actually know that they purchased insurance and therefore do not file claims.

Selling *de facto* compulsory bundled policies has the very obvious advantage for retailers that they do not need to do any selling to the policyholder. The "tick-of-the-box" nature of the transaction means in many instances that they do not have to comply with agent's licensing regulations as they do not provide advice. Compulsory insurance reduces adverse selection (the tendency of the worst risks to apply for insurance). In theory, all of these benefits could be passed onto the client in the form of lower premiums. In practice, however, selling bundled products often results in abuse. In South Africa, 34 to 38 per cent of low-income clients at retail stores regularly pay for purchased items in monthly instalments and have bundled insurance. However, less than 8 per cent of those individuals are aware that they have insurance.⁵

In theory, regulators could improve the situation by compelling stores to (i) specifically inform customers that they have insurance and (ii) advise them that they can purchase the required coverage elsewhere. In practice, this may be difficult to enforce. Even if customers were aware of their options it might make little difference to their behaviour, for a number of reasons. Firstly, the most significant cost of the purchase is the item itself (plus interest costs). Secondly conducting transactions in rural areas can be expensive and difficult for clients; they may not think it worthwhile to shop around for alternative insurance. Or given the dearth of alternative low-income insurance providers in such areas, there may also simply be no other option.

Bundled insurance linked to the product sold could in theory provide relatively cheap cover for some of the most important and costly assets that low-income clients purchase. In practice though, selling products in this manner is often abused; clients are either unaware that they have purchased insurance or have been sold very expensive insurance.

⁴ In other words, 5 per cent of credit customers obtain credit life insurance from a different source.

⁵ Data sourced from the FinScope 2004 survey.

2.2 Bundled insurance unrelated to the product sold

There are few instances of bundled microinsurance where the insurance product bears no relationship to the good or service sold. In India, the Sankat Haran Policy sold by Iffco-Tokio provides accidental death and disability cover. The cover is obtained when clients buy a 50-kg fertilizer bag of Iffco and Indian Potash brands. The receipt for the fertilizer bag acts as proof of payment and the policy document is printed on the fertilizer bag. The amount of cover is US\$90 in the event of an accidental death and US\$45 for certain categories of dismemberment and disability. The insured is the purchaser of the fertilizer bag and a single person can hold multiple policies up to a maximum of US\$2,260 in cover. Claiming on the policy appears somewhat arduous as claimants must submit a variety of documents to Iffco-Tokio directly. This scheme, however, may well be the largest commercial microinsurance scheme in the world. By the end of 2005, the Indian newspaper *The Hindu* (Revathy, 2006), reported that it covered 25 million persons.

Essentially the scheme sells pre-paid insurance, in the sense that the retailer buys the fertilizer, including its insurance component, from a wholesaler. The *retailer pre-pays the insurance premium*, so there is no need for the insurer to collect premiums from the client or, indeed, from the retailer.

On the face of it, in a competitive market for fertilizer and accidental death and dismemberment (AD&D) insurance, it is hard to imagine what value is offered to the consumer by this type of embedding. Any consumer who wanted either fertilizer or AD&D insurance could buy it separately in the required quantities without needing to buy the two together. However, the rural Indian market is not competitive and this may be the only means of distributing such insurance. It is also possible that the addition of AD&D insurance provides an incentive to purchase a particular brand of fertilizer (in much the same way some Visa cards come with similar coverage linked to travel). Another explanation for the existence of this scheme is the regulatory requirements in India, which stipulate that insurance companies must sell a percentage of their policies to socially disadvantaged clients and derive a percentage of total premiums from clients in rural areas.

The insurance is compulsory, which in theory should control adverse selection. With this particular configuration, however, this is not necessarily the case. A person with an extremely risky profession can buy a bag of fertilizer, keep the receipt and the policy document, repackage the fertilizer and sell it on to another farmer; although given the number of people buying insurance, adverse selection is not likely to become a problem.

This model is only appropriate for microinsurance products with single premium payments. In addition, it is unlikely that products offering anything other than minimal coverage could be sold in this fashion. If they were, it would increase the cost of the good or service to a point where a customer who did not want insurance might be disinclined to purchase that good or service.

2.3 Voluntary insurance linked to the product sold

In many developed countries, when a durable good is sold it is quite common for the seller to offer insurance, usually in the form of an extended warranty on the item. A South African retailer, Makro, which sells consumer durables, also provides voluntary extended warranties. The premiums for some of these warranties are sufficiently low to appeal to the low-income market. For example, a two-year warranty extension costs R299 (US\$47) for refrigerators priced below R6,000 (US\$943). This kind of warranty could be beneficial for microenterprises. Many consumer durables purchased from retailers are used in informal household enterprises. Refrigerators in South Africa, for example, are commonly used to run informal catering businesses or to retail meat bought from wholesalers. It may be quite difficult for low-income consumers to purchase independently offered extended warranties, and so the option of being able to purchase it with the product might be appreciated.

2.4 Voluntary insurance unrelated to the product sold

The South African supermarket chain Shoprite targets low-income consumers. Inside each supermarket, there is a “Money Market Counter” where customers can carry out a variety of financial transactions. The counters are intended to increase shopping convenience, facilitate customer loyalty, and provide a range of transaction services, including payment for television licences and of utility bills, with approximately 220 third parties represented at the counters. During the 2004/05 financial year, the number of transactions conducted at “Money Market Counters” reached around 21 million per month.

The supermarket sells funeral insurance at the counters on behalf of the insurer HTG Life. HTG Life is a member of the HT Group, which also includes a funeral service business (Doves and Saffas funeral parlours). The policy covers specified nuclear families (policyholder, spouse and children). The eligibility criteria and cover are given in Table 46.

Table 46

HTG funeral insurance product⁶

<i>Feature</i>	<i>Description</i>
Monthly premium	Determined by age of oldest life covered. 14–55: US\$3.93 (R25); Ages 56–68: US\$6.61 (R42)
Eligibility	Policyholder must be between the ages of 14 and 68. No medical examination required.
Benefit	Ages 0–6: US\$197 (R1,250); ages 7–13: US\$393 (R2,500); ages 14 and older: US\$787 (R5,000); policyholder: US\$787 (R5,000); spouse of policyholder: US\$787 (R5,000).

Source: Chamberlain et al., 2006.

Shoprite is responsible for marketing, selling and collecting premiums on the policy, while HTG Life handles policy administration, claims management and payout. Shoprite earns commission on each policy sold. Since the target group does not have bank accounts with standing order or direct debit facilities, premiums are paid in cash at the “Money Market Counters”.

In the event of a claim, payment may be made in two ways. Beneficiaries have the option of using any of the HT Group funeral providers or other identified agents for the funeral. If this option is selected, the beneficiary qualifies for a discount on the funeral services provided. The second option is to apply for a cash claim, which is payable from the HTG Life head office within 48 hours of presentation of the required documentation. If the customer requires a cash payout, the money is paid into the bank account of the policyholder and/or beneficiaries. If the policyholder or beneficiaries do not have a bank account, the money is paid out at a participating funeral parlour. However, as the latter method poses a security risk, HTG Life tries to avoid it where possible. This raises questions as to the usefulness of the policy for lower-income clients who are still largely “unbanked”. The competitive advantage Shoprite and HTG Life have in being able to collect insurance premiums from clients without a bank account may result in slower policy payouts.

The advantage of selling (and collecting premiums) through the retailer’s extensive distribution network are undermined by the fact that claims payments can only be made at participating funeral parlours. Despite its attractive distribution and cost features, this model has not reached significant volumes of policyholders. In the three years of its existence, fewer than 6,000 policies have been sold. One of the key problems raised is that it is a “pas-

⁶ Information as at December 2005.

sive” distribution model relying on customers approaching the counter and asking for the product. This differs from traditional broker/agent models where products are actively sold. There is also little incentive for the in-store Shoprite employees to sell the product.

South Africa provides another interesting example of using retailers to sell voluntary insurance. The clothing stores Jet and Edgars (both part of the Edcon group) provide insurance to low-income clients (though Edgars sells predominately to higher-income clients) for those who qualify for the store’s credit card. There are more than 280 Jet stores located across South Africa, while Edgars owns more than 150 South African stores (*see Box 83*).

Edcon and Hollard Insurance Ltd established a joint venture, Edcon Insurance Services, in June 2001. The two companies agreed that the Edcon group would sell a wide range of insurance policies underwritten by the Hollard’s life and non-life insurance companies. The insurance policies have store branding (i.e. not that of the insurer) to exploit high retailer brand awareness.

Both Edcon and Hollard Insurance were actively involved in the design of the products. All the products were designed to suit the needs of the average Edcon customer. Policies are sold over the counter. The sales personnel provide the insurance as a “tick box” offering and therefore do not need to fulfil the regulations that govern agents. Edcon Insurance Services is responsible for the marketing and sales of the policies, while the retailers collect the premiums and pass them on to Hollard. The insurance company manages the policy and claims administration and handles the actual payment of claims.

The rationale behind the store-card model, as used here, is that monthly premiums can be more easily collected if they are simply added to the store account balance. In other words, the monthly premium is paid together with the total monthly instalment due (which can be paid in cash). A drawback of this approach is that customers who do not qualify for the cards cannot purchase insurance. The model therefore excludes individuals who could potentially afford a small monthly insurance premium, but do not qualify for credit.

The scheme has proved highly profitable. During the 2004/05 financial year, a growth of 23.4 per cent in active insurance policies was experienced, increasing Edcon’s profit for insurance-related products from US\$30.2 million to US\$41.4 million.

Box 83

Retailers and rural areas

The stores described all have branches in rural areas, which may be more common in South Africa than other countries. Various pieces of South African legislation from 1923 divided South Africa into “prescribed” (mostly urban) and “non-prescribed” (mostly rural) areas, and strictly controlled the movement of black South Africans between the two. Apartheid authorities

actively discouraged permanent black settlement in large urban centres. The existence of these laws and other restrictive apartheid laws helped to create “urban slums in rural towns”. The population density of these areas created opportunities to establish retailers that might not exist in other rural areas of developing countries with more dispersed rural populations. Consequently, this delivery model for microinsurance might be more effective in reaching rural South Africans than the rural populations in other countries.

One advantage of selling voluntary products through a retailer, or other organization with many low-income customers or members, is that the distribution channel can use its significant client base to get discounts from insurers. This is in addition to any savings that they are able to pass on to consumers as a result of lower distribution costs. Indeed, in some developed countries, for example the United Kingdom, the cheapest life insurance policies are often sold by supermarkets.

Although not retailers, some trade unions have experience selling voluntary insurance. In the United States, the largest trade union federation, the AFL-CIO, has negotiated a set of discounts on a variety of consumer and financial products for its members (*see Box 84*). It is mentioned here because many retailers have membership clubs or loyalty schemes that can be tapped in a similar way to that in which the AFL-CIO has made use of its membership to sell insurance.

Box 84

AFL/CIO’s Union Privilege Scheme

From 1986, “Union Privilege” has used the AFL/CIO’s vast membership to negotiate discounts on a range of products and services, including a variety of insurance products. The scheme promises to ensure the quality of insurance provision through careful selection of partner insurance companies and regular monitoring. It has also used its bargaining power to get additional riders to make the policies more attractive to members. For example, for one life insurance product, workers on union-sanctioned strikes, lockouts or involuntary lay-offs that last for more than 30 consecutive days do not have to pay premiums for 3 months during the industrial action. For the AD&D product, policyholders do not need to pay accident insurance premiums for the period of a union-sanctioned strike or lockout, up to a maximum of one year. This gives value to the members it serves (they buy insurance at a cheaper price), it strengthens the unions by providing an additional reason for members to join, and it provides a new stream of income to participating unions – commission income.

Source: Adapted from Koven, 2006.

Another advantage for policyholders is that the distributor bears significant reputation risk. The distribution channel is the face of the policy. If policyholders are dissatisfied with the policy, they may terminate their relationship with the retailer or trade union.

One concern with voluntary insurance products sold by non-specialized distributors is that the consumer is often buying an important product with life-changing consequences. Policies sold by retail stores are often sold through a “tick of the box”. The terms and conditions may be presented to the customer by a store attendant, or simply left hidden in a stack of other information. This approach may be inexpensive, but it may also be of poor value. In theory, the terms and conditions are on the policy document, but for microinsurance this is not an appropriate means of educating the customer, nor does this transaction method facilitate questioning by a potential client about the terms of policy.

3 Conclusions

It is premature to draw firm conclusions from the few examples of retailers as distributors of microinsurance. What follows are some initial thoughts, many of which will need to be tested through further research.

Leaders and followers

The driving force behind the development of retailer microinsurance distribution in these examples seems to be the initiative either from the retailers looking to expand their value offerings and increase client loyalty (as in the Shoprite case), and/or from insurers needing to fulfil regulatory requirements (as in the Indian and South African cases). In these few examples, retailers or regulators are leaders, and insurers are followers.

The advantages of retailers as microinsurance distribution agents

- The trust in the retailer brand is one of the critical attractions of this distribution channel. It reduces the sales effort and, hence, the cost of delivery. However, retailers also need to consider the brand risk they would face if insurance did not meet clients’ expectations.
- A key advantage of this distribution mechanism is that it allows for cash premium collection and claims payment at places that are more conveniently located than the offices of the insurance company and its agents. In developing countries, this will ensure that the model does not simply cannibalize the existing insurance market (as may be the case with retailer distribution in the developed countries with saturated insurance markets), but actually expand the market to individuals who would not otherwise have access to insurance.

However, not all retailers have fully exploited this opportunity (e.g. Shoprite's claims-payment procedure).

- An obvious advantage of retailer distribution is that it provides centralized access to the retailer's client base, which would otherwise be very difficult for insurers to reach. In a number of cases, the retailer controls access to the client base, which means that the insurer cannot access it without continuing the relationship with the retailer (e.g. for retail account holders). This places retailers in a powerful negotiating position with insurers.

Key problem of voluntary insurance sold through retailers

It is clear that retailers can reduce the costs of insurance distribution to the low-income market. There are even a few examples of voluntary insurance sold through retailers. The problem seems to be that retailers are not necessarily good at *selling* insurance. Staff need to be trained and motivated to sell voluntary insurance. This experience mirrors that of many microfinance institutions. As the Shoprite example demonstrates, it is unclear how successful this passive approach can be for a product that is famously "sold not bought".

Bundled products: Problem of abuse

- Although bundled insurance products simplify premium collection and ensure a better risk profile, it is not clear whether consumers necessarily benefit. Lower costs and risks are not always reflected in the premium.
- Given the low literacy rates associated with the target market, the risk of mis-selling products to clients, who may be unaware of their bundled purchase, is significant.
- Even if the relationship is not abused, embedding ultimately reduces the incentive of the insurer to ensure that its product meets the consumer's needs.

Bundled products: Problem of ongoing protection

Insurance bundled with consumer credit products has the same problems as some MFIs' insurance products linked to loans, where the need for insurance coverage extends beyond the loan repayment period.

Bundled products: The limits of bundling insurance with an unrelated product

Embedded insurance products that are unrelated to the primary good or service sold seem to be a means of marketing the primary good or service and tend to be quite basic in their cover and benefits. Any insurance product that offers significant value is likely to cost more and potentially push up the cost of the primary good or service to a point where it is no longer attractive.

“Tick-the-box” insurance: The pros and cons

There is an inherent trade-off between product simplicity and lower costs on the one hand, and advice and education on the other. While retailers can reduce distribution costs by using simple products that are sold through a “tick-the-box” method, it is often low-income clients who need financial advice and education the most. However, these services increase the costs of policies and decrease affordability for clients. As a minimum, appropriate disclosure of product information is required to ensure that clients are aware of the features and conditions of the products they have purchased. This is not only in the business interest of the seller (increasing retention and building long-term clients), but also avoids mis-selling and the concomitant risk of costly regulatory intervention.

So what then is the potential of the retailer distribution model for microinsurance? The preceding discussion reaches conflicting conclusions on the potential and reality of distributing microinsurance through retailers. Retailer distribution presents opportunities to overcome some of the key barriers to microinsurance distribution, which could benefit both providers and clients of insurers.

However, it is clear that this distribution method is still a relatively new and untested phenomenon in the low-income market. In particular, the evidence on the ability to sell voluntary insurance through retailers is less than positive and there are shortcomings in the current models that need to be addressed to ensure success. Critically, retailers need to find ways of replacing the market-making function of traditional insurance intermediaries without undermining their low-cost distribution advantages. Without this, it is unlikely that the voluntary models will achieve any scale in markets that are not familiar with the benefits of insurance.

Bundled insurance on the other hand has achieved much success for the retailers and insurers. In the examples reviewed, however, little benefit has been passed to the clients who are probably paying too much and are often unaware of their cover. If disclosure is improved, this model can provide valuable protection to clients who would otherwise not have access to such insurance. Critically, a shift has to be made to providing value to the client rather than using insurance simply to extract larger profits. This new opportunity comes with great potential for consumer abuse and will require active monitoring and regulation by consumer groups and authorities.

Microinsurance: Opportunities and pitfalls for microfinance institutions

Craig Churchill and James Roth¹

The authors appreciate the substantive comments and suggestions provided by Javier Fernandez Cueto (Compartamos), Lemmy Manje (ILO), Michael McCord (MicroInsurance Centre) and Constantin Tsereteli (Constanta Foundation).

As discussed in Chapter 4.2 and elsewhere, microfinance institutions represent an important distribution channel for extending insurance to the poor. However, it is also important to turn the lens around and look at this issue from the MFI's perspective.

To begin with, should an MFI get involved in offering insurance? When microfinance institutions are interested in insurance, their primary motivation is often to reduce their credit risk in the event that borrowers or their family members experience death, illness or other losses. If insurance can help protect the households in such circumstances, it will indirectly safeguard the MFI's portfolio.

Another significant motivation behind the interest in insurance is to improve the welfare of their clients. MFIs typically have dual missions to alleviate poverty or promote economic development while generating a profit (or covering their costs). The social mission of improving the welfare of poor households can be enhanced through the protection provided by insurance.

There are also a number of legitimately commercial reasons why MFIs might be interested in providing insurance, such as:

- **Enhancing retention:** Many MFIs realize that they need to offer a variety of products to enhance retention, so that even when clients do not want a loan, they may still appreciate a savings account, a wire transfer service or...insurance protection.
- **Product profitability:** A diverse product menu provides cross-selling opportunities and spreads the acquisition costs for a client across multiple products, enhancing product profitability.

¹ The examples from Compartamos (Mexico) and Constanta (Georgia) were provided by the readers and were not drawn from the case studies.

- **Diversifying income streams:** Microinsurance creates an additional source of income either from profit if the scheme is provided in-house (and well-managed), or from fees if done in partnership with an insurer. The latter situation is of particular interest to MFIs, which welcome opportunities to earn income without taking risks.
- **Reach out to new markets:** In heterogeneous low-income communities, there may be persons who are not interested in credit or savings, but are keen on insurance, although in reality, few MFIs have taken advantage of this benefit, since it would require having a delivery channel exclusively for insurance, which most MFIs have thus far avoided.

Of course, there are also disadvantages to offering insurance. It is a different business from savings or credit, requiring different expertise. Even offering insurance products in partnership with an insurer can be time-consuming and demanding. A number of organizations, like ProCredit Banks in Eastern Europe, have no interest in offering insurance, directly or indirectly, so they are not distracted from their core services. Furthermore, low-income households have finite resources. If an MFI offers insurance, some clients might have to choose between repaying a loan or making a deposit and paying an insurance premium.

If an MFI believes that there are more pros than cons, and decides that it wants to branch out into the brave new world of insurance, there are two key questions it needs to consider when offering microinsurance:

1. Through what institutional arrangement should it offer insurance?
2. What types of cover should it offer?

I Institutional arrangements

If an MFI wants to offer insurance to its clients, there are four main ways to do so: a) in partnership with an insurance company, b) by creating its own insurance brokerage, c) by self-insuring or d) by creating its own insurance company.

I.1 Partner-agent model

Under what circumstances is one option preferable to the others? Chapter 4.2 describes in detail the advantages and disadvantages of collaborating with an insurance company, and strategies for improving the partnership. Certainly, if no partner is available or willing to offer insurance through the MFI, then it could go on its own. However, the possibility of not being able to find

an interested insurance partner is becoming increasingly less likely as more insurers seek opportunities to reach new markets. MFIs are also becoming more convincing, arming themselves with arguments and experiences to persuade insurers that this is indeed a valuable market opportunity for them.

In general, if an MFI cannot entice an insurer into a partnership, it is probably not effectively communicating what it has to offer. Many insurers are attracted to the prospect of accessing many new clients through a cheap distribution network.² MFIs should recognize that insurers and bankers may have very different attitudes toward the masses of low-income people. For bankers, whose money is at risk when they lend, the poor are a risky market. Insurers, however, tend to be interested in ways of reaching an expansive market cost-effectively. Volumes speak volumes.

To make the partner-agent work effectively for MFIs, the following recommendations emerge from the experiences of MFIs around the world:

- **Tell them what you want:** To get good products and processes from insurers at a decent price, MFIs need to know what they want and they have to sit in the driver's seat in the negotiations. The larger they are, the more demanding they can be. Several MFIs, including Compartamos (Mexico) and some Opportunity International affiliates, have designed their own product specifications and then sent requests to insurers to bid on their proposed product.
- **Know your stuff:** MFIs need to speak with authority, using language that insurers understand backed up with compelling data. One advantage of an MFI is that it can often create useful actuarial data from its own experience of working with clients, to which the insurer otherwise would not have access. For example, before it began negotiating with insurers, FINCA Uganda researched and documented its historical mortality experience.
- **Do not be afraid to switch partners:** MFIs do not have to be wedded to one insurance partner forever. If the insurer is not performing, the MFI can look for a new partner, although this should not be taken to extremes – ASA, an Indian MFI, changed insurance partners too frequently, which caused some confusion among clients and staff.
- **Choose a trustworthy insurer:** It is often preferable to work with a well-known insurance company because it helps create trust and confidence in insurance. Without trust, clients will be unwilling to pay premiums today against the promise of a possible future benefit.
- **Involve the insurer:** The alternative to changing partners is to get existing partners to improve. Shepherd (India) found that it was useful to invite insurers into the field to enable them to understand the target market better

² For advice on negotiating with insurance companies, see Churchill et al., 2003.

and to begin to recognize the difference between insurance and microinsurance. This can be reinforced through an annual review meeting with the insurer.

- **Ask for training:** A major challenge in introducing insurance is training the MFI's employees, particularly the frontline staff who are responsible for sales and service. Several MFIs have persuaded their insurance partners to train their employees in insurance in general and in the products in particular.
- **Manage claims:** An efficient claims-processing system is one of the most important points for negotiation. As described in Chapter 4.5, when the benefit amounts are small, MFIs should insist that they pay the claims (at least for life insurance), and then be reimbursed by the insurer, on the basis of documentation appropriate for their clients.
- **Create a review committee:** Since claims processing tends to be one of the most contentious issues, Shepherd formed a review committee, with representatives from the MFI, insurer and clients, which meets quarterly (or more often if necessary) to improve claims processes.
- **Eliminate exclusions:** Strive to persuade insurers to drop as many exclusions as possible, even if the MFI has to pay a higher price, because that simplifies the product and makes it easier to explain to customers. It also reduces claims rejections that could cause significant public relations problems for the MFI.
- **Maintain and analyse data:** MFIs should maintain good information about insurance performance, enabling them to develop expertise over time and to push insurance partners for better deals. An appropriate and “actuarially-approved” MIS is crucial (*see Chapter 3.5*).
- **Determine the costs:** MFIs need to conduct a costing analysis to determine how much they need to earn in commission (or through a premium markup) to cover their administrative expenses.
- **Own the clients:** Some entrepreneurial insurance companies might be interested in stealing the clients in the future. The MFI should always “own” the client. This can be done if the MFI is always the institution that sees the client.
- **Share the profits:** Instead of receiving a commission, the Zambian MFI Pulse has negotiated a profit-sharing arrangement with Madison Insurance (*see Chapter 3.6*), which corresponds more with the spirit of microinsurance, if the MFI is willing to take a bit of the risk.

1.2 Insurance brokerage or agency

The creation of an MFI-owned insurance brokerage is essentially a more sophisticated version of the partner-agent model. This approach, often used by credit union networks (*see Chapter 4.1*), facilitates access to formal insur-

ance for MFIs and members alike. As with the partner-agent model, this arrangement has the advantage of outsourcing the risk to formal insurers.

The advantage of the brokerage arrangement over the basic partner-agent model is that an organization affiliated to an MFI (or a group of MFIs) develops insurance expertise to negotiate the best deals on behalf of the MFIs and their members. The brokerage is not tied to any one insurance company, so it can explore various options on behalf of its two main customers, the MFIs and their clients. In addition, the brokerage is not limited to using MFIs as the distribution channels. Once it understands the needs of the low-income market, it can explore other strategies for extending insurance to poor households and businesses. As mentioned in Chapter 4.5, Opportunity International has recently launched such an initiative (the Micro Insurance Agency). The insurance brokerage could also be seen as a first step towards creating an insurance company (described in more detail below), although that does not necessarily have to be the objective.

1.3 Going solo

A third option is for MFIs to self-insure, in other words, to carry the risk themselves. There are compelling reasons why some microfinance institutions would want to self-insure, as well as some equally strong arguments against it.

Some MFIs do not want to work in partnership with an insurer for ideological reasons. Microfinance institutions with strong social missions may not believe that profit-making firms should provide financial services to the poor. MFIs with such ideological commitments will not be swayed by arguments that profit-making insurance companies could possibly provide cheaper and better insurance to their clients.³

Among the non-ideological reasons for self-insurance is a belief that the MFIs (or their customers) will have to pay extra for the insurer's overhead. For the most basic products, like credit life, that logic might be valid. However, basic credit-life insurance largely benefits the lender since it means the MFI does not have to solicit loan repayments from the deceased's survivors.⁴

³ In some cases, ideological preferences can play an important role in partner selection. For example, Shepherd selected public insurance partners because it deemed it a national duty to work with the state insurer.

⁴ There is some debate about the usefulness of credit life insurance. Some MFIs feel that it is an unnecessarily complicated means of dealing with loan losses due to death, and they prefer to just write off the loan and provision accordingly. Such an argument might be valid for predictable loan losses due to death, but would not be appropriate if an MFI experiences a natural disaster or other covariant risks. The provisioning approach is also not relevant for small MFIs that cannot afford to write off loans or for MFIs granting larger loans, creating a concentration risk, or if the mortality rates are volatile or changing, as in an area with high incidence of HIV/AIDS.

If the MFI really wants to reduce the vulnerability of its customers, more complicated products are required – products that an MFI probably cannot offer on its own.

Both TYM (Viet Nam) and CARD (Philippines) had negative experiences trying to enhance customer value on their own. They provided credit life on a self-insurance basis and generated significant surpluses. Consequently, they thought it would be a good idea to offer additional benefits, by including other family members or by covering additional risks. They added these benefits, however, without assessing the impact that they might have on claims. As a result, CARD's pension plan nearly bankrupted the company, and TYM's hospitalization benefit threatens to do the same even though the benefit is extremely modest.

Another concern surrounding self-insurance is the extent to which an MFI will cope if it experiences catastrophic losses. This problem cannot be emphasized enough. The primary reason why MFIs should not self-insure – besides not having the expertise to price and design products appropriately – is because they will have difficulty meeting claims if many clients are affected by a peril at the same time. Since they are not formal insurers, they do not have access to reinsurance, which is how insurers cope with covariant risks. Reinsurers essentially create a larger risk pool than an insurer can achieve on its own, by spreading risks across national boundaries, but only licensed insurers can access reinsurance (*see Chapter 5.4*).

VimoSEWA (India) learned this lesson the hard way. After several years of negative experiences with insurance partners, it began offering in-house health insurance in 1996, and then added asset insurance in 1998. Initially, VimoSEWA's transition to self-insurance had positive financial and service benefits – claims were paid faster and not rejected, and VimoSEWA began building up some reserves. However, when the January 2001 earthquake struck Gujarat, over Rs. 3.4 million (US\$75,000) was required to satisfy claims, causing a severe financial strain. Prior to the earthquake, annual payouts for asset protection were below Rs. 30,000 (US\$662). This experience helped VimoSEWA appreciate the need for reinsurance, and led the organization back to the partner-agent approach.

While natural disasters like floods and earthquakes are usually used as examples to scare MFIs away from self-insurance, it was something more mundane – a truck accident in which several borrowers died – that convinced ASA to find an insurance partner. If MFIs start offering larger loans, they may find that the death of just a few borrowers can seriously drain a self-insurance fund. Smaller MFIs are also more vulnerable if they self-insure because they have a small risk pool (although they are also in a weaker position to strike up an appropriate partnership with an insurer).

The main point is that a self-insuring MFI must think carefully about how it will control covariant risks. It could exclude such risks to limit its exposure, which is what Spandana does, although such an approach leads to clients being abandoned when they need help most. Moreover, excluding cover does not help the MFI manage its credit risk in a disaster situation. Alternatively, a self-insuring MFI could solve this problem by buying catastrophe cover with an insurance company, so the MFI covers idiosyncratic risks in-house while outsourcing covariant risks to an insurer.

A further argument against going solo is that in many countries it is illegal to offer insurance without a licence. Regulators generally do not bother with small microinsurance schemes. Some organizations manage to disguise their schemes by calling the service a member benefit instead of insurance. Insurance regulators may be willing to look the other way, or may not even realize that the scheme exists. However, once it achieves significant scale, it is bound to attract attention. In addition, regulated MFIs are probably not allowed to keep insurance liabilities on their balance sheets, so for them (or MFIs planning to transform), self-insurance may not be an option. Donors are also becoming increasingly wary of supporting organizations that are circumventing insurance regulations.

Some MFIs, like TYM, choose self-insurance because they want to retain the funds as a source of loan capital. The situation in Viet Nam is unique because the regulatory environment has prevented MFIs from accessing wholesale finance, except from donors who have become somewhat parsimonious. Consequently, TYM (and other Vietnamese MFIs) have had to be creative to satisfy their funding requirements. TYM's insurance fund has been a source of loan capital, despite the fact that it is unwise to combine insurance and credit risks.

Another reason why MFIs might want to self-insure is that they do not want to share the insurance profits with another organization. Similarly, if going solo means lower overhead costs, the coverage could be cheaper for the clients. Consequently, some MFIs contend that they can provide greater customer value without involving an insurer. As shown in Table 47, using the claims ratio (the percentage of premiums returned to policyholders in the form of claims) as an indicator of customer value, the evidence suggests that self-insurance provides greater value, albeit from a very small sample of experiences.

Table 47

Does self-insurance provide greater client value?

<i>Self-insurance</i>		<i>Partner-agent</i>	
<i>MFI</i>	<i>Claims ratio</i>	<i>Insurer</i>	<i>Claims ratio</i>
TYM	53	AIG Uganda	37
Spandana	85	Madison	10

In-house schemes should be more efficient. A lot of money is saved on administration and marketing because the product tends to be simple and generally there is one product for all. In addition, in-house schemes do not comply with technical rigour or insurance regulation, both of which are expensive. They also do not have to pay for the additional overhead and profit margin of an insurance company.

Besides costs, another aspect of customer value is the service standard for claims payments. For MFIs that have tried working with insurers and given up, problems with claims –including delays and rejections – are probably the number one reason for the divorce. If the MFI self-insures, it can pay claims quickly and impose less onerous documentation requirements on the beneficiaries. For example, when Spandana was collaborating with LIC, claims often took two to three months or more to be paid. The MFI moved the scheme in-house, and now 73 per cent of claims are settled within seven days.

Experts have mixed opinions on the topic of self-insurance. Leftley (2005) feels strongly that there are no good reasons why MFIs should take on insurance risk as long as there is existing underwriting capacity in the country. Other experts are more open-minded about the issue, willing to concede that self-insurance might even be preferable to the partner-agent approach if certain conditions are met: 1) the MFI is large enough to pool risks (at least 10,000 members) and those risks are reasonably homogeneous, 2) the product is kept simple, 3) the MFI obtains catastrophe coverage from an insurance company, 4) the MFI makes use of appropriate technical assistance to help with product design, pricing, data management and performance monitoring and 5) regulators will allow it.

Finally, there are cases where an MFI chooses to go solo, despite an active insurance market, because it cannot entice insurance companies to provide the coverage sought by clients at an affordable price. Going solo under such conditions needs to be done with extreme caution. If the market is unwilling to provide a service for a particular price, there is often a good reason: it may not be viable.

1.4 Creating an insurance company

The fourth option is for an MFI or an association of MFIs to create their own insurance company. For many years, in many countries, credit unions and cooperatives have satisfied their insurance needs through insurers owned by the association and its members. As discussed in Chapter 4.1, the typical approach has been for the credit unions to create a brokerage company that facilitates access to insurance for the CUs and members alike. Over time, the brokerage builds up sufficient expertise in underwriting, settling claims and managing data, and amasses sufficient funds to form a credit-union-owned insurance company.

In some jurisdictions, it might be appropriate for other types of MFIs or MFI associations to create their own insurance company. Indeed, CARD has done just that, creating a mutual benefit association that is “owned” by the members, but structured to meet the insurance needs of the MFI. Some advantages of creating an insurance company over self-insurance are that it:

- separates the credit and insurance risks into different organizations,
- ensures that expertise is engaged in the management of the insurance business,
- can collaborate with multiple distribution channels to extend insurance to the poor and hence reach many more people,
- gives the microinsurer access to reinsurance.

Compared to the partner-agent approach, an MFI-owned insurance company allows the MFI greater influence on product design and service standards. Furthermore, it enables any profits to be redistributed to the policyholders. However, the management of the insurance company should be kept at arm’s length from the MFI so as not to jeopardize the soundness of its insurance decisions. In particular, careful consideration should be given to the investment strategy, since it is unwise to mix the credit and insurance risks by investing too great a proportion of premiums in the MFI’s loan portfolio (*see Chapter 3.6*).

The transformation of an informal insurance scheme into an insurance company is not without its challenges. In some jurisdictions, there may be significant start-up and reporting requirements that do not justify the effort. For years, SEWA has had its sights set on creating an insurance company. However, it has not been able to raise the minimum required capital and the Indian insurance regulators are not interested in making an exception for microinsurance.

2 The type of insurance

One of the key factors in deciding what type of insurance an MFI should offer is its motivation for doing so. In general, an MFI's motivations fall into two categories: 1) organizations that want to offer insurance primarily to reduce their credit risks by being able to recover loans if borrowers die or are too ill to repay and 2) MFIs that are primarily motivated to assist their clients in managing risks and to cope with crises and economic stresses (*see Box 85 for an example of the second category*). Of course, many organizations may be motivated by both objectives, but their primary motivation will probably influence their choice of insurance services and the means of offering them.

Box 85

Reducing the vulnerability of the poor: The case of Shepherd, India

Shepherd is very clear that its motivation for offering insurance is to reduce the vulnerability of the poor. In doing so, it has designed a comprehensive strategy for risk prevention and risk management that incorporates insurance among a range of measures, including:

- **Food security:** Group members are requested to save a fistful of rice at each meeting; as this rice-saving accumulates, group members can either borrow from it or it can be donated to more needy community members.
- **Income security through life insurance:** Shepherd's core business is the provision of savings and credit through self-help groups (SHGs), whereby loans are typically used to support income-generating activities. To protect the household from the death of a breadwinner, group members (and their spouses) can choose between four different life insurance schemes that Shepherd offers on behalf of insurance companies.
- **Income security with livestock:** For SHG members who take out loans for cows and other livestock, Shepherd promotes a three-pronged strategy: prevention, promotion and protection. *Prevention* is addressed through regular cattle-care camps that Shepherd organizes so that a veterinarian can identify and treat poor households' main asset. For *promotion*, Shepherd has trained barefoot veterinarians to educate SHG members to properly care for their animals and to provide ongoing treatment if necessary. For *protection*, Shepherd offers voluntary livestock insurance on behalf of an insurance company covering the natural and accidental death of the animals.
- **Health security:** In 2003, Shepherd introduced UniMicro Health Insurance in partnership with United India Insurance Corporation (UIIC) to cover in-patient treatments (*see Table 18 in Chapter 3.1*). To complement the insurance product, Shepherd organizes regular medical camps to con-

duct check-ups for illness and disease. Shepherd also offers emergency loans that are primarily used for childbirth through its Sugam Fund (*see Box 23 in Chapter 2.4*).

- **Asset security:** A rider on the UIIC UniMicro product includes hut insurance that pays a benefit of US\$100 if the policyholder's house burns down.

Source: Adapted from Roth et al., 2005.

In general, it is easier for MFIs in the first category to meet their objectives than for those in the second category. Owing to its relative simplicity, basic, credit-linked insurance is more likely to be available to the MFI and more affordable to the client, and it is more likely that the MFI could offer it on its own, whereas comprehensive coverage – to protect the poor from the many risks that they really worry about – is very difficult for an MFI to offer on its own and may not be available from other sources.

If MFIs are motivated to offer insurance primarily because they want to help their clients manage risks, and if they are not already offering savings, then that should be their first priority (where the law allows them to accept deposits). As described in Chapter 1.2, the poor are vulnerable to a range of risks and economic stresses, many of which represent relatively small but nagging expenses for which insurance is not an appropriate solution. Insurance covers larger losses and is very risk-specific; for example, a life insurance policy cannot help someone whose valuables are stolen, or health insurance cannot help someone rebuild a destroyed house. Savings (and emergency loans) are more flexible and responsive than insurance in coping with risks. The main difficulty with savings as a mechanism for coping with risk is that the funds are frequently insufficient to cover the loss and their use leaves the saver vulnerable to further risk.

MFIs with a broader development objective should also consider helping their clients to prevent or mitigate their risks, like Shepherd which offers health workshops and cattle-care camps. While an MFI might undertake prevention strategies to fulfil its social mission, such measures could have the additional advantage of reducing claims, having a positive and cost-effective impact on claims experience (*see Chapter 3.9*).

There appears to be a trade-off between reaching many people with a simple product and reaching fewer people with more complex, varied, and voluntary insurance. In general, it makes sense for MFIs to start with a simple life policy to learn about insurance. Simple products work best because they are easier to administer and easier for clients to understand. Once MFIs know how to manage insurance risks (either on their own or in partnership with an insurer), then they can move on and provide coverage that better

meets clients' needs. Similarly, once the market better understands what insurance is, and begins to develop an insurance culture, clients will be more willing to pay for broader benefits.

In selecting insurance products, it is important for MFIs to recognize that they cannot cover all risks and clients cannot afford to buy numerous insurance products. Indeed, this might be a reason to avoid insurance altogether, since the MFI does not want clients to pay insurance premiums at the expense of loan repayments or savings deposits. If the MFI does decide to go ahead with insurance, the challenge is to figure out the most cost-effective solutions to their clients' primary problems.

2.1

Integrated or stand-alone?

To offer insurance cost-effectively to the poor, one of the main strategies is to combine it with another financial service, i.e. with savings or loans, so that the transaction costs can be minimized. Since credit is the core business of most MFIs, the insurance and loan terms can coincide so clients can renew their loan and their insurance at the same time. By linking cover to the loan, the MFI can also make the premium easier to pay by adding it to the loan amount. However, as discussed in Chapter 2.3, not everyone wants a loan, and even people who want loans do not want them all the time, so credit-linked insurance provides incomplete coverage.

Consequently, a link between savings and insurance not only provides more continuous coverage than the credit-insurance link, but it can also significantly reduce the transaction costs. For the life savings product, for example, there are no transaction costs for clients since they do not have to pay a premium (they accept a lower interest rate on their savings instead). For other savings-linked insurance products, premiums can also be paid by automatically deducting the amount from the savings, although there is a public relations risk that depositors may not be aware that the money is being deducted (*see Chapter 3.3*).

From an MFI's perspective, the insurance products that make the most sense are integrated into or linked to the organization's core services of credit and possibly savings. Not only do integrated products enhance efficiency, but also they bolster the MFI's core products. Property insurance, for example, makes the most sense when linked to assets purchased with a loan from the MFI, such as a house, business equipment or livestock.

Still, there may be justification for considering stand-alone insurance. Although the main examples from the case studies of stand-alone insurance offered through MFIs were the credit unions, other types of MFIs might see this as a possible growth area. One of the biggest challenges would be the

staffing structure, since the sale of stand-alone insurance would require greater expertise of field staff (*see Chapter 3.7*).

The strongest argument in favour of offering stand-alone insurance products is to retain policyholders who want to stop borrowing. MFIs that offer loan-linked insurance should seriously consider a continuation policy that enables clients to retain insurance cover between loans. As long as the MFI has a premium-collection method that is independent from a loan, this is a fairly low-risk product because it does not require additional screening.

A second reason to offer stand-alone insurance is to expand the MFI's market, reaching people it cannot serve through savings and loans. If the MFI does adopt that approach and it sells microinsurance to non-members, the organization (or its insurance partners) is vulnerable to adverse selection risks. To control this risk, insurance should only be offered to persons who have joined a group for purposes other than accessing insurance, or increase benefits gradually over time (*see Chapter 3.1*).

2.2 Issues with long- and short-term insurance

Short-term insurance is easier for MFIs to offer than longer-term coverage. It is easier to predict whether an insured event will occur in the next year than over the next five or ten years. If an insurer makes errors in the pricing, it is only committed to those mistakes for a short period of time, after which it can make adjustments. It is strongly recommended that microfinance institutions do not get involved in long-term insurance on their own.

Furthermore, many MFIs are not in a position to offer long-term insurance in partnership with an insurance company, because their delivery systems typically revolve around short-term loans. In India, Tata-AIG (an insurer) and the Bridge Foundation (an MFI) linked up to sell a long-term life insurance product that required premiums to be collected over many years. The pilot proved unsuccessful because the loan term and the insurance term did not coincide. When clients decided to stop borrowing, the MFI did not have a mechanism for them to continue to pay their premiums, resulting in many lapsed policies.

An MFI that uses a savings account as a delivery mechanism could theoretically offer long-term insurance. Yet microfinance institutions may see long-term insurance offered on behalf of an insurance company as competition for the MFI's own savings products.

2.3 Health insurance

Health insurance is a difficult product for MFIs to offer, but there are some examples – including BRAC and Grameen in Bangladesh, SEWA and Shepherd in India, AssEF in Benin, MFIs collaborating with Microcare in Uganda, and TYM in Vietnam – that provide insights and lessons for other MFIs. The link between the MFI's core services and health insurance is not particularly strong, and therefore most MFIs tend to steer clear of such a complex and expensive insurance product.

Yet two compelling arguments may entice MFIs into the choppy waters of health insurance. First, MFIs with a strong social agenda may see themselves as much more than just a microfinance institution, which is certainly the case with the MFIs that provide health insurance in Bangladesh and India.

The second argument is that health expenses, for borrowers and family members, could adversely affect an MFI's loan portfolio. This was a motivation behind FINCA Uganda's initial relationship with Microcare. AssEF had a similar motivation. Its market research determined that, without protection against the financial risk associated with illness, AssEF's members often used their income-generating loans to pay for health expenses, and then had difficulty repaying the loan. Their other options of covering health costs – withdrawing from their savings accounts, borrowing from moneylenders or selling productive equipment – all had negative effects on the microenterprise, and consequently the MFI's loan portfolio. AssEF sought to address the root cause of this problem by providing health insurance.

Based on the experiences of MFIs offering health insurance, there are three possible models:

1. Health provider model

Both BRAC's Micro Health Insurance Programme and Grameen Kalyan are built around their own healthcare clinics, which provide the vast majority of the healthcare services. In BRAC's case, the clinics and the insurance scheme are managed separately; in both cases, the clinics and the health insurance scheme are independent from their parent company's microfinance operations. The only link is that microfinance members get a premium discount, and the microfinance staff members are informally involved in marketing.

2. Partner-agent model

VimoSEWA, Shepherd and Constanta Foundation (Georgia) all provide health insurance on behalf of an insurance company. As a result, the MFIs are primarily responsible for the sales and client education, but (except for

VimoSEWA) are not involved in product design, data management or claims payments, nor are they involved in the provision of healthcare.

3. *Self-insurance*

Both AssEF and TYM provide the insurance on their own, including designing the product and carrying the risk. In TYM's case, it offers a hospitalization benefit of VND 200,000 (US\$13) payable only once a lifetime, so it is both simple and of limited value. AssEF, however, provides very comprehensive coverage, including 70 per cent of many healthcare expenses as long as they are performed by contracted healthcare providers. The MFI's insurance department pays the claims directly to the clinics and hospitals.

MFIs interested in offering health insurance would be wise to keep the scheme at arm's length from their microfinance activities. Unlike life insurance, where it is advantageous for the MFI to manage claims, with health insurance the MFI should steer clear of the administrative burden of claims processing. In addition, as discussed in Chapter 2.1, it is difficult for health microinsurance to be self-sustaining. Consequently, MFIs need to ensure that any insurance losses do not adversely affect their microfinance operations.

Ironically, AssEF has experienced the opposite problem: the microinsurance scheme has been suffering because of the poor performance of the loan portfolio. Since microinsurance was integrated as an additional voluntary service for microfinance members, the insurance initially reaped the benefits of the members' confidence. However, due to increasing competition among microlenders, the MFI experienced high delinquency and drop-out rates. These difficulties led to loss of staff motivation and a distraction away from premium collection to loan recovery.

2.4

Insurance for MFIs?

Besides considering what insurance products to offer their clients, microfinance institutions also need to consider their own insurance needs. Interestingly, AIG's involvement in microinsurance in Uganda began during negotiations on commercial coverage for FINCA. MFIs working in partnership with an insurance company should consider packaging their entire insurance needs – those of the MFI and its clients – into the discussions to achieve a better deal. In addition, if staff are covered by some of the policies that they also sell to the MFI's clients, it helps ensure that staff understand the policy. If they do not like the product, there is a strong likelihood that the MFI's clients will not like it either.

In general, MFIs should assess whether they need the following types of corporate coverage:

- **Life and health insurance for employees:** MFIs should be concerned with protecting their most valuable assets, their employees. Modest investments in life and health cover for employees and their families can reap significant returns in the form of staff retention, high productivity and fewer working days lost to illness.
- **Fidelity insurance:** Bonds guarantee a payment or a reimbursement of financial losses resulting from dishonesty, failure to perform and other acts. One type of bond is fidelity insurance, which protects the MFI from losses incurred due to fraudulent acts perpetrated by specified types of staff.
- **Money storage and handling:** Any MFI that stores or transports cash is vulnerable to theft. As the amount of cash in the safes or being transported to banks increases, MFIs would be wise to supplement their internal control and security policies with insurance coverage.
- **Property loss or damage:** Many microfinance institutions have a lot of money invested in their branch and head office infrastructure, and those offices are often located in high-risk communities. Certainly, protection against fire, vandalism and other property loss is worth considering.
- **Deposit insurance:** In many countries, deposit insurance is a public service provided by or in association with the central bank for regulated deposit taking institutions. However, such an arrangement could be delegated to an insurance company that has better information about the health of certain financial institutions than the central bank. For example in Poland, TUW SKOK provides deposit insurance on all savings accounts in credit unions up to €20,000 (US\$25,000).

3

Conclusions

There are no reasons why an MFI has to offer insurance. Indeed, most MFIs should focus on improving the effectiveness of their lending activities and introducing savings facilities before they distract themselves with insurance.

If an MFI decides to offer insurance, it needs to recognize that it cannot address all risks for everyone; it needs to determine the most cost-effective way to help clients solve their primary problems without undermining the organization's core business. It also should consider if it has sufficient skills to provide insurance, either on its own or with an insurance company. Insurance training for microfinance managers will strengthen their ability to negotiate appropriate products on behalf of their clients.

Microfinance institutions that are keen to offer insurance to protect themselves, their clients, or both, should explore the potential for partnerships with insurance companies. Where such partnerships are possible, they should adapt the products and systems to accommodate the characteristics and preferences of the low-income market. Where the regulatory environment allows, MFIs or associations of MFIs could also consider creating brokerage firms or even their own insurance companies, although these need to be managed at arm's length to ensure that credit policies do not influence insurance policies, and vice versa.

When determining what products to offer, and through what channels, an important consideration is how an MFI can best create an insurance culture in its target market. For example, what can the MFI do in terms of product design, service standards and customer education to create conditions in which low-income households appreciate insurance and are willing to pay for additional benefits?

There remains a gap between the risks that the poor really worry about – such as affordable healthcare and protection from natural disasters – and the insurance products that MFIs can realistically offer, even in partnership with an insurer. Microfinance institutions have to be realistic about what they can and cannot provide, and at what cost. Indeed some types of insurance for the poor, such as health insurance, may need to be subsidized, which might not make sense for an MFI with a commercial business model.

5 The role of other stakeholders

5.1 The role of donors

Alexia Latortue

The author appreciates the insights and suggestions provided by Frank Bakx (Rabobank Foundation), Jeremy Leach (FinMark Trust), Jeanette Thomas (CGAP) and Ellis Wohlner (consultant to SIDA). The author is particularly grateful to Aude de Montesquiou (CGAP) for her excellent research support and extensive feedback.

Poor people in developing countries enjoy limited protection against the numerous perils of life. Losers in the “lottery of geography”, they live in countries with large informal economies and weak institutions. Governments strapped for cash and with inefficient systems are often unable to provide adequate social protection. The private and formal sectors of these countries are typically tiny and closed to the majority of citizens. Insurance companies are no exception, and they often do not appreciate the market opportunity at the bottom of the pyramid. Exclusion from both social protection and formal insurance is thus the norm.

In this context, what is the role of international development aid? This is the central question the chapter addresses. Building on the aid effectiveness initiative of the Consultative Group to Assist the Poorest (CGAP), this chapter seeks to understand donor systems and to examine how they can hinder or foster the application of good practices. It also draws from the *Preliminary donor guidelines for supporting microinsurance* to suggest specific strategies donors may employ to support the expansion of microinsurance services.¹

Microinsurance is growing in popularity among donors, perhaps because it addresses the core vulnerabilities of the poor. The objectives of microinsurance – helping low-income people manage risks and stopping the vicious cycle of poverty and vulnerability – respond to many donor priorities. Both faces of Janus described in Chapter 1.1 are highly relevant to donors. Whether from a social protection point of view or within the context of a private sector/financial sector approach (or a combination of both), donors are interested in the contributions of insurance to the Millennium Development Goals. However, this donor enthusiasm is cause for both caution and optimism.

¹ This document was prepared by the CGAP Working Group on Microinsurance (2003).

Donors² are well-placed to step in and address both the public- and private-sector market failures. The intelligent use of subsidies can serve as a catalyst to spark the interest of private actors in a new and unfamiliar market segment, provide much-needed investments in social infrastructure such as local healthcare centres, help build the capacity of local players, and promote policy changes to remove barriers to access.

I An analytical framework

Microinsurance is multi-faceted and requires work at all levels of the market (*Figure 34*). Starting with the clients, what is key is (1) the capacity of retail providers to offer insurance services appropriate for low-income persons (“micro” level), (2) the supporting infrastructure and second-tier support for micro-level providers to reduce costs, improve market information and transparency, and reach scale (“meso” level) and (3) the policy environment (“macro” level).

Figure 34

An analytical framework for donor support for microinsurance



² For the purpose of this chapter, donors include bi- and multi-lateral agencies, regional development banks, foundations, and socially responsible investors. Much of the discussion will also be applicable to other organizations that fund microinsurance or design and manage microinsurance programmes on behalf of donors, such as international non-governmental organizations (NGOs), consultants and international networks.

Acquiring a thorough understanding of the market at all three levels is an important first step for any donor considering a microinsurance intervention. The country context matters, as does the state of market development. To enable microinsurance to flourish, it is essential to understand clients' needs and to promote insurance literacy. A range of insurance providers (commercial insurance companies, cooperatives, mutuals, etc.) and delivery mechanisms are needed to serve people without access where they live and work. For these retail providers to be strong and transparent, they require access to a host of services from reinsurance and training to national information clearinghouses. Finally, the overall policy and regulatory environment is important for the protection of consumers, the reduction of barriers to entry and the promotion of competition.

2 Donor requirements to effectively support microinsurance

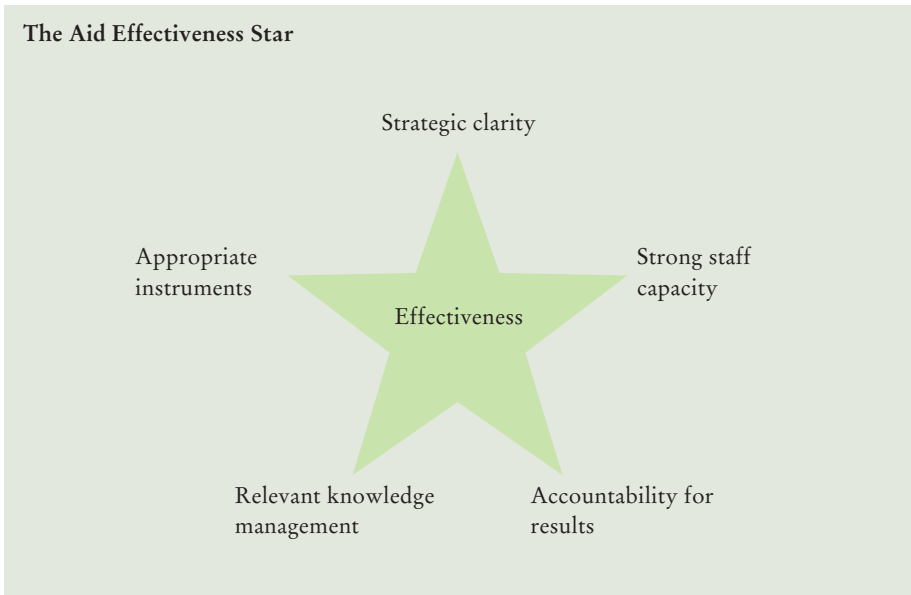
Without the right knowledge and resources, overzealous donors may design ineffective programmes that never reach significant scale and waste money. Worse, failed microinsurance schemes can breed distrust among clients who are often wary of insurance services to start with, and among insurance providers sceptical of this new market segment. Well-directed donor interventions, however, can create new focus, know-how, innovations and powerful demonstration effects in expanding poor people's access to insurance services.

Much has been learned about what it takes for donors to manage effective programmes though CGAP's work on the effectiveness of aid.³ Depicted as the Aid Effectiveness Star (*Figure 35*), five core elements provide a useful framework to discuss the donor prerequisites needed to successfully support insurance services for the poor. While all elements of the Aid Effectiveness Star are important, not all donors can be equally strong across the five. Rather, donors should use the five elements to assess their internal systems and identify areas for improvement. They can use this analysis to determine 1) *whether* to intervene at all in microinsurance and 2) *how* to intervene using their comparative advantage.

³ For example, see Cook et al., 2005.

Figure 35

The Aid Effectiveness Star



2.1

Strategic clarity

Does the donor possess a clear vision and understanding of what microinsurance is, how it contributes to the agency's overall development goals, and what it takes for the agency to support microinsurance effectively?

Donors' interest in microinsurance could stem from various entry points, including social protection, health, agriculture, risk management or financial services. So it is not surprising that microinsurance programmes can originate from several departments within the same donor agency. At the ILO, for example, the Social Finance Programme looks at the financial sector angle, while the STEP programme considers the social protection perspective. Few development agencies have dedicated insurance departments or units.

Opportunities for sharing information and making a real impact may be lost due to the scattered presence of microinsurance in donor agencies. Donor staff often function in silos. Colleagues working on the same issue, though looking at it through different "lenses", may not speak to each other or even know of each other's activities.

There are few stand-alone microinsurance projects in donor agencies' portfolios, but rather insurance is usually included as a component of larger projects. As such, microinsurance might not get the specialized attention it requires. Rarely does one part of the organization have mandatory vetting or quality-control authority.

Strategic clarity also affects how donors interact with key stakeholders on the ground – the government, private sector and civil society. A strong penchant for one face of Janus over another (e.g. social protection versus private sector) will influence who donors engage with and the content of negotiations. Different policy issues will emerge as well. From the social protection face of Janus, a core question for donors may be “how far does promoting microinsurance let governments off the hook for providing social security?” With the private sector face, donors might ask “how appropriate is it to transfer donor subsidies to private sector companies?”

Donors do not view the subject through neutral lenses. Strategic clarity affects how objectives are set, the expertise recruited, and the type of monitoring implemented. Decisions that appear operational in nature may actually have major strategic implications. For example, opting for group-based, as opposed to individual, policies generally results in far more inclusive and cost-effective insurance. Whatever the entry point, clients should be at the centre of all decisions made. In particular, donors should consider clients’ needs for risk-management strategies broadly – insurance might not always be the best response. Other services such as savings can be quite effective in helping clients manage risk.

2.2 Strong staff capacity

Are there sufficient staff in the donor agency with insurance expertise relative to the size of the insurance portfolio? Even when the donor relies on outsourced expertise, a minimum level of “insurance literacy” is needed internally.

Involvement in this field requires a basic understanding of insurance principles and practices. In addition, depending on the type and level of intervention, donors may require specific technical expertise such as insurance management and accounting, actuarial sciences, underwriting and claims adjustment, or knowledge of insurance regulation.

However, insurance expertise is scarce among most donor agencies, with the lack of microinsurance knowledge even more acute. This problem is compounded by an overall trend for donor staff to become generalists. The lack of specialization of staff has serious consequences for the quality of programmes. While it is not realistic to expect all agencies to have in-house microinsurance expertise, staff managing projects that include insurance should have a minimum level of “insurance literacy” to outsource intelligently and know the right questions to ask.

Unfortunately, in the case of microinsurance, there is even a dearth of readily available expertise available for contracting. Several donor agencies rely on the same, limited number of microinsurance consultants. Donor networks in some of the specialized areas required for insurance, for example actuarial science and underwriting, are small or non-existent.

Besides having some in-house expertise in insurance, effective donors should possess local market knowledge. Decentralized donors with staff based in countries/regions may have an advantage in this regard. Without an understanding of the local environment, donors cannot properly judge whether implementing partners are assessing the priority needs of the target population, the types of risks they face, existing risk-management mechanisms and the additional protection they need.

2.3 Appropriate instruments

Does the donor agency have instruments appropriate for innovative pilot programmes? Can the donor deploy small amounts of funding flexibly, with a long-term perspective? Can the donor work directly with the private sector?

The range of donor instruments available includes technical assistance, grants, loans, equity, guarantees and policy support. Since microinsurance is still in an experimental stage, donors should adopt a patient and cautious approach, providing small amounts of funding, perhaps for longer periods of time. Asking for co-funding from partners is one way to test real, long-term commitment. From the beginning, plans for reaching sustainability should be discussed.

Insurance is a highly specialized activity. Thus, whenever possible, donors should seek to work with existing institutions that already have this expertise, such as insurance companies or perhaps health mutuals (*mutuelles de santé*). Working with formal insurers raises the question of the appropriateness of providing public subsidies to privately-owned companies. Most development agencies enthusiastically support private sector development and public-private partnerships. Yet, many donor staff feel uncomfortable about granting scarce donor funds to private players. Furthermore, much remains to be learned about how to structure this support and how to plan for exit (*see Box 86*).

Box 86

Unleashing the catalytic role of the private sector with public subsidy⁴

Donor subsidy, when well-targeted and time-bound, can incite the private sector to help address gaps and overcome market failures. The following are some principles for the provision of subsidies to the private sector:

- Donors should only fund activities that are accepted as being pro-poor and of high quality, and thus able to yield measurable social returns
- Donor funding should enable or accelerate a process that otherwise either would not have taken place or would have taken much more time to occur
- Donors should be careful not to subsidize something that the private sector would be willing to do on its own, and not to unfairly subsidize the competition of a private-sector initiative
- Private companies should provide some of their own funds (co-funding), and the margins/profits realized from the activity should not be excessive
- Donors should identify partners where the highest possible leverage effect is likely
- The goals of the activities funded should be achieved in a commercially viable manner, i.e. the private entity must recognize a viable business case

In markets where private-sector insurers indicate an interest in the low-income market (e.g. India, South Africa), donors can play a catalytic role in drawing them in and linking them to institutions able to fulfil front office functions. In such cases, money is less important than knowledge, tools and networking.

However, the reality of certain countries is that formal insurers are years away from entering the low-income market. In these countries, various types of non-specialized institutions offer insurance, ranging from credit unions to health mutuals. Donor funding may be usefully deployed in this approach, especially technical assistance and grants. Technical assistance can help improve market research, product development, training and client education. Grants may be used to defray the purchase of fixed assets or to cover operating losses. To avoid creating disincentives for good management and efficiency, donors should only cover operating losses in the first few years when the client base is small and premiums do not yet fully cover costs.

⁴ This box is based on an interview with Jonathon Ridley of Enterplan, who is involved in managing DFID's Financial Deepening Challenge Fund, which has provided grants to private-sector firms, including insurance companies. See DFID/FSCF, 2004.

Donors can also selectively deploy loans and guarantees to support microinsurance. Loans to governments from multilateral development agencies are often used in social protection programmes. Guarantees are mostly appropriate to help link reinsurers to microinsurers (*see Box 87*). Partial guarantee funds where the reinsurer takes a significant amount of the risk, but has some coverage from the donor funds, can help introduce reinsurers to this new market. The key to successful guarantees is setting the incentives in such a way that insurers manage as if their own money were at risk, and ensuring diminishing benefits over time. Donors should obtain expert assistance to structure the guarantee funds appropriately and should monitor their impact and cost-effectiveness.

Box 87

Providing support through donor guarantees

A DFID guarantee was critical during the start-up phase of the Nsambya Health Insurance Plan (NHHP), now known as Microcare. The NHHP had no reserves, nor could it access reinsurance (normally the next line of defence for insurers after reserves) because it was not yet a regulated insurer. DFID's subsidies enabled NHHP to test methodologies for serving the poor, such as delivering health insurance to low-income communities by tapping into the clientele of a microfinance institution. To limit its own risk, DFID reserved the right to monitor the pricing and achievements of the objectives of NHHP's business plan.

Source: Adapted from Dror and Preker, 2002.

Certain costs, such as claims costs, should rarely be covered by donors. Clients should face the true costs of well-managed insurance from the beginning. An exception might be social protection schemes that have access to significant sources of stable funding (from governments, for example) and can subsidize premiums for very poor or high-risk persons over the long-term. Even then, the risk of drop-outs and/or financial collapse is high when the subsidy is withdrawn.

For now, the bulk of donor support is appropriately targeted at the retail level. Over time, investments at the market infrastructure and policy levels will become more important as donors seek to help foster a coherent overall system for increasing poor people's access to insurance services. Typically, instruments best suited for work at the market infrastructure and policy levels include grants, technical assistance and policy support.

2.4

Accountability for results

Is there transparency in the donor agency for all projects that include microinsurance? Does the donor monitor performance of microinsurance programmes, and take action based on results?

Improving the accountability of public subsidy is of paramount importance. Doing so requires more than ex-post evaluations. Incentives for accountability should be introduced at all stages of the project cycle.

Since microinsurance often emanates from multiple departments within the same agency, it is important to have up-front clarity about the most desired outcomes. What is good microinsurance? Is it achieving financial sustainability and attaining social objectives, e.g. meeting clients' priority needs, improving healthcare quality or advocating better labour codes? Donors should reach agreement on the common expectations of performance, whichever face of Janus they are pursuing.

Agencies also have to decide whether they wish to have a single quality assurance focal point to review all projects with microinsurance components. Ensuring that adequate due diligence is carried out (whether by the donor, outsourced experts or the implementing partner) is also part of improving accountability up front.

Exit strategies should be discussed at an early stage as well. Exit is only possible when sustainable market capacities are built. If this does not happen, donors will find it extremely difficult to withdraw support without jeopardizing poor people's access to insurance. For example, the Rabobank Group and its reinsurance company, Interpolis N.V., are having difficulty exiting from Yasiru in Sri Lanka, a microinsurance scheme they have been supporting since 2000. If Rabobank exits, Yasiru will either have to dramatically reduce its costs or increase its annual premiums by about 60 per cent to fully compensate for the reduced financial support.

To ensure the best possible implementation, donors should select outsourced expertise carefully and conduct an appraisal of potential partners. Contracts with both technical service providers (for example, if a consultant is hired to help manage the project) and the microinsurance provider should be performance-based to tie continued support to the achievement of key milestones. For example, disbursements could depend on meeting minimum performance thresholds such as the number of people insured and a benchmark expense ratio, complemented by a satisfactory review by an actuary.

A mix of on- and off-site monitoring of microinsurance projects is vital to identify problems early on, ensure proper utilization of funds and document lessons learned. Donors should request quarterly reports from their microin-

insurance projects. Besides key performance indicators, the quarterly reports should include qualitative information from management with progress updates on the business plan, budgets, achievements, problems encountered, trends and any management issue such as major human resource changes.⁵ Monitoring by an actuary at least annually is also highly advisable. The actuarial review should include a comprehensive appraisal of performance, including the adequacy of premium rates and claim reserves.

As with savings, the important responsibility of protecting poor people's money cannot be taken lightly. The challenge for donors is to balance their role as risk takers (i.e. funding innovations that may or may not succeed) with that of being responsible funders. Failed microinsurance programmes can have negative long-term consequences for clients, actual and future providers, donors and governments.

2.5 Relevant knowledge management

To what extent are donor agencies learning from their own and others' experiences, and feeding that learning back into new programme design? Are donors making use of the increasing volume of microinsurance literature to learn about a variety of models, possible linkages and partnerships?

The complexity and multi-faceted objectives of microinsurance require that donors share information and coordinate at several levels. Donors should coordinate with (i) private sector insurers, (ii) relevant government social protection agencies to synchronize governmental and microinsurance efforts and (iii) other funders to establish common strategies and avoid duplications. The GTZ-initiated donor consortium to support VimoSEWA is a good example of a joint effort to provide donor funding in a coherent manner. The consortium includes CGAP, the Ford Foundation and the ILO (for research support). All agencies discuss continuously and co-ordinate their funding to support VimoSEWA's business plan.

Though a lot has been written on microinsurance recently and some training courses exist for practitioners, there is little training targeted specifically at donor staff. Especially since the topic is relatively new, donor staff need various fora to exchange experiences and discuss the reasons for the failure and success of microinsurance programmes.

Donors can also identify partnerships with other donors whose "star" complements their own. For example, a development agency with strong

⁵ Standards for monitoring are still under development and appropriate benchmarks are also in their formative stages (see Chapter 3.10).

staff expertise could team up with a donor that has flexible grant-funding to pilot programmes. Donors with strong data management systems and insurance knowledge could help promote information clearinghouses.

The following section discusses in more detail the types of donor actions likely to deepen poor people's access to insurance services.

3 Types of donor support for microinsurance

Donors are not in the driver's seat in developing insurance services for poor people. The donor role is to serve as a catalyst, with governments, the private sector and civil society taking the lead. Nonetheless, donors can have great influence on how quickly and well – or poorly – microinsurance reaches scale. Donors should wait for the demand from stakeholders in countries, rather than actively promoting microinsurance.

The choice of intervention should be founded on a good understanding of all levels of the market, the state of market development, and the donor's own strengths. A range of possible donor interventions, starting with clients at the centre, is presented below. Not every donor can or should work on all these levels.

3.1 Clients

Microinsurance providers are the closest to actual and potential clients, and are best suited to understand client needs and provide client education. That said, donors have a role in commissioning research and creating tools. Whenever possible, donor-funded work in these areas should be public goods that multiple providers can use.

Client education on the benefits of insurance services is key to the success of microinsurance. The costs of designing appropriate materials for client education and training staff to provide these “non-insurance” services are not negligible. Ultimately, these costs should be factored into the marketing expenses of providers. However, donors can help by:

- investing in designing materials for client education, including bearing the cost of translating and adapting existing materials for specific contexts;
- offering training courses on client education;
- subsidizing the upfront development costs of client education for new microinsurance providers;
- ensuring that a strategy (and associated budgets) for client education is part of providers' business plans and

- including information on insurance in the growing number of financial literacy campaigns.

Too often, **client demand is assumed, misunderstood or over-simplified.** Donors can help improve understanding of client demand by:

- funding the development of user-friendly tools for conducting insurance market surveys;
- funding national market surveys to better understand the needs and risk-management mechanisms of low-income households (the demand side) and how the needs are currently addressed by public, private and informal organizations (the supply side); the FinScope surveys are a good example of this kind of donor support (*Box 88*).

Box 88

FinScope surveys: Getting to know the market⁶

The FinMark Trust, which was started with a grant from DFID, has pioneered the use of specialized household surveys of financial services usage through its *FinScope* surveys in South Africa.

FinScope tracks the changing patterns of access to financial services across all the main product categories – transaction banking, savings, credit and insurance – in the formal and informal sectors. For example, the 2005 South Africa FinScope survey found that 34 per cent of people had some kind of insurance. Much of this coverage came from informal or semi-formal providers such as burial societies. The survey showed that “unaffordability” was the main barrier to funeral coverage. The survey also indicated that at least one third of the 53.5 per cent of un-banked South Africans have access to a cell phone and that those people who are aware of cell phone banking believe it will make the cost of financial services diminish.

The FinScope surveys are powerful tools for public and private sector decision-makers to think about how to reduce barriers to access and how to innovate to reach new market segments, including low-income and poor people. FinScope South Africa is now fully funded by the private sector, and is being replicated in other countries.

3.2

Micro level: Retail microinsurance providers

Retail providers and their distribution channels are the backbone of delivering insurance services to the poor. Building the capacity of institutions to provide appropriate, good-quality and affordable services to the low-income

⁶ For more on Finscope, please see www.finscope.co.za.

market segment is one of the greatest challenges in increasing poor people's access to insurance services. However, the need for donor support should not always be assumed. For example, Delta Life in Bangladesh has never had any donor support. Though some question the quality and appropriateness of Delta's products, it is undeniably one of the oldest and largest microinsurers. Nonetheless, in many markets, for insurance to be widely available, donors have a role to play.

Donors should prioritize working with existing formal insurers to serve the poor whenever possible. They can also help build the capacity of grassroots organizations such as cooperatives. Donors should generally not push or encourage new microinsurance providers. In some areas, however, existing providers may not be interested in serving the poor and/or face legal and regulatory limitations in expanding their services. Effective donor responses can then range from helping to build a viable business case for formal insurers to working to improve the legal framework or cautiously exploring support for new providers.

Given the close association of microinsurance with microfinance, donors should be particularly careful not to encourage MFIs to bear the risk of providing insurance. Insurance is a specialized activity that requires specific competencies few MFIs have or can profitably develop. Instead, donors can help MFIs negotiate with formal insurers. Even through partnership models, some MFIs may not be solid enough to venture into insurance.

Capacity-building is needed in almost all cases, no matter what model or approach is chosen, including the partner-agent model. While formal insurance companies already possess insurance skills, they often need guidance to improve their marketing, distribution and claims systems to effectively serve low-income households.

Perhaps the most important donor contribution is to make **technical assistance** – and to a lesser degree, financial assistance – available to the retail providers at the micro level. Figure 36 outlines the areas in which technical assistance is needed to strengthen institutions. It also suggests the types of technical service providers available (since donors tend to fund technical assistance, not provide it directly) and the various mechanisms used to transfer knowledge and skills. The issue of technical assistance is explored in more detail in Chapter 5.5.

Figure 36

The what, who and how of microinsurance technical assistance

Areas of technical assistance (what?)

- Client education
- Market research
- Feasibility studies
- Product development/refinement
- Business planning
- Operations (procedures, manuals)
- Marketing

Technical service providers (who?)

- Independent consultants
- Private consulting firms
- Networks
- Associations
- Training institutes/Universities
- International NGOs
- Donor projects/staff
- Insurance companies (as part of corporate social responsibility or through foundations)

Delivery mechanisms (how?)

- On-site advisors
- Short-term consultants
- Management contract
- Training
- Study visits
- Tools
- Multi-donor funds

Building the capacity of providers starts with defining the skills needed, then designing the best package of services (for example, see Goodwin-Groen et al., 2005). Selecting the right technical service provider and delivery mechanism is crucial. Donors should focus on the technical service providers' track record and their staff with some basic knowledge of microinsurance. Especially if not using the partner-agent model, donors may need specific insurance skills in-house.

Capacity-building requires patience and time. Donors should make a long-term commitment, using performance-based contracts. Both parties should respect their engagements: for donors that means timely service and disbursements. If results are poor, donors should withdraw support.

Unfortunately, there do not appear to be sufficient, quality technical assistance providers and training institutes with microinsurance skills, which poses a real challenge for strengthening retail providers and building up donors' microinsurance portfolios quickly.

Donors can also provide *financial assistance*. The range of financial assistance, from purchasing fixed assets to providing guarantees and covering operating losses was described in the discussion on instruments. In general,

donors should not capitalize new insurance entities, nor is it generally recommended that they subsidize premiums (*see Box 89*).

Box 89

Lessons learnt the hard way: Illustrations from India

Yeshasvini Trust. The Government of Karnataka partially subsidized the premiums of Yeshasvini Trust. However, when the subsidies stopped, the premiums had to be doubled from Rs. 60 (US\$1.35) to Rs. 120 (US\$2.70) per adult, and the number of policyholders plummeted from 2.2 million to 1.45 million.

Karuna Trust. Initially, UNDP fully subsidized the premium for members below the poverty line and other disadvantaged groups. Many members were not aware they were insured. When the premium subsidy was removed two years later, about 70 per cent of the members wanted to drop out – they did not want to start paying for services that had previously been free and felt that the premium was too high. After a major client education and information campaign, half the clients ultimately renewed and paid for policies.

3.3 Meso level: Market infrastructure and public goods

Poor information on the target clientele, the limited number of specialized technical service providers, the lack of ready-made information systems, and the scarcity of reinsurance can all seriously constrain the expansion of insurance to poor clients.

Retail providers require a host of services and information to perform effectively, assess risks appropriately, reduce costs and become more transparent. As seen above, donors can contribute significantly to funding, brokering and even providing some of these services. Long-term access to these services, however, will require local and regional solutions that are usually private-sector led. Supporting the emergence of local or regional market infrastructure and public information goods is a fairly new area for donors. The range of areas that require donor subsidy at the meso level is quite varied and includes supporting market infrastructure like networks and training providers, promoting transparency and fostering knowledge management.

Supporting meso-level institutions/mechanisms

- **Networks/trade associations.** International networks can help strengthen microinsurance providers, as Opportunity International has done. Donors can make best use of their time, expertise and resources by channelling funding through well-managed networks. Donors can also work with insurance associations to sensitize them to the low-income market segment.

- **Information clearinghouses.** Typically, formal insurers have little if any information on the low-income market segment. Clearinghouses with information on the most important risks facing this market segment are sorely needed. Data on the cause and frequency of specific risks is essential to price products correctly and identify appropriate loss prevention programmes. Donors should work together to promote and fund the development of such clearinghouses at the national and regional level. Donors can also support clearinghouses with information on qualified technical assistance providers.
- **Training/technical assistance service providers.** Fostering the supply of private sector technical assistance and training providers is very challenging and best done by joint donor programmes. Donors can help build the capacity of local/regional providers through training of trainers (TOTs) programmes, materials development and business planning.

Promoting transparency

- **Management information systems (MIS).** Homegrown information systems are expensive and time-consuming to develop. Donors can invest in building MIS to improve the quality and accuracy of information flows. More transparent reporting allows for better management and can attract partners such as reinsurers. Systems developed with donor funding should be open-source, to facilitate duplication and adaptation.
- **Performance indicators/standards.** Donors should share information on the performance indicators they currently use, including definitions for each. Those with the most technical expertise should lead a process to agree on the main menu of indicators required for the good management of insurance schemes – donor reporting should draw on those indicators, and not require long lists of indicators that are irrelevant to microinsurance managers.
- **Benchmarking.** Benchmarking microinsurers' performance across peer groups can assist managers in improving performance (*see Chapter 3.10*). It is also useful for reinsurers and donors to better understand the performance of microinsurance. Benchmarking is only possible if donors insist on transparency and agreement is reached to share and pool data collected following the same standards.

Fostering knowledge management

- **Research on clients.** All microinsurers should include the costs of better understanding client demand in their operating expenses. However, punctual, major national surveys can be valuable to numerous providers, especially in markets where information is scarce and hard to collect.

- **Tool development.** As more donors and their outsourced expertise gain experience in microinsurance, they should fund the development of tools and guides that could be published on the web for the use of all. Tools that could be of great use include guides for conducting market research and feasibility studies.
- **Lessons learned and good-practice guidelines.** Capturing lessons learned from what works and what does not is useful for new entrants and struggling programmes. Donors should include knowledge-management components in their programmes and proactively record lessons learned.

3.4 Macro level: Supportive policy environment and advocacy

As described in the next two chapters, the policy and regulatory environment in some countries can be detrimental for microinsurance. A supportive environment for microinsurance, however, allows for the emergence of different types of providers. Only donors with the right technical skills (including staff in the field), good retail-level knowledge, strong influencing capacity and the trust of governments should engage at the macro level. Donors should proceed carefully in attempting to influence government policies, especially in countries where there is not much experience at the retail level.

- **Government advocacy.** Donors may be well-suited to undertake a range of advocacy efforts. Advocacy could include promoting better social security, enhancing ministries' capacity to improve healthcare, labour standards and so on, and reducing entry barriers for new players. Often, research is required to prepare strong evidence-based messages for government.
- **Regulatory frameworks and supervision.** While working at the retail level, donors sometimes encounter obstacles in regulatory systems. This retail experience can help them lobby more effectively for specific changes. For example, when the government of India was preparing microinsurance regulations, it posted a concept note on the Insurance Regulatory and Development Authority's (IRDA) website and many donor agencies, including GTZ and the ILO, submitted official comments on the paper.
- **Consumer protection.** Donors can promote greater transparency in premiums, the exact nature of cover, and the claims settlement procedure to ensure that clients know what they are purchasing. Consumer protection is linked to client education, but can also include legally-mandated guidelines for the terms used in insurance policies, and complaint systems to collect client grievances.

4

Conclusion

Helping poor people mitigate and plan for risks is an important priority. Insurance is just one among several strategies for coping with risk. Successful microinsurance is based on a solid understanding of client demand, and often requires partnerships across a range of stakeholders from the private and public sectors. Donors can help broker such alliances, attract private sector players, support government initiatives and fill market gaps in capacity and information. Donors are most effective when they develop the appropriate internal pre-requisites and analyse markets well before acting. They should carefully balance their role as innovators and risk-takers with a keen understanding of the possible long-term negative consequences of poorly designed schemes.

An enabling regulatory environment for microinsurance

Martina Wiedmaier-Pfister and Arup Chatterjee

The authors have received very useful feedback on this chapter from a number of people, including: Klaus Fischer (Laval University), Serap Oguz Gonulal (World Bank), Brigitte Klein (GTZ), Jeremy Leach (FinMark Trust), Hunter Murdock (attorney) and Bikki Randhawa (World Bank).

The cases analysed in this book demonstrate that low-income persons are insurable. Furthermore, there is evidence that microinsurance business operations can be sustainable. However, the question that needs to be raised is whether microinsurance operations are supported by a regulatory framework that is conducive to protecting policyholders and developing insurance markets that include the low-income segments of the population.

The primary function of insurance regulators and supervisors¹ is to protect consumers. This is manifested in at least three ways:

1. **Protecting policyholders in general** by ensuring the solvency of the insurers, which includes determining that insurance products may only be offered by licensed entities (both insurers and intermediaries) that remain financially sound and meet their obligations.
2. **Protecting individual policyholders**, including prospective policyholders, from mis-selling and improper handling of claims, and ensuring that their grievances are redressed in a timely fashion.
3. **Developing insurance markets** by improving market efficiency and including persons who currently have no access to or are unable to afford insurance through appropriate product design and delivery mechanisms.

Insurance authorities do not attach equal importance to these three aims. Much of their work is concentrated on the first two. Although improving market efficiency by correcting market imperfections is a classic task of supervisors, not all insurance authorities agree on a market development function. An analysis of the International Association of Insurance Supervisors (IAIS) database of national insurance regulations reveals that few member countries have an official development mandate. To fulfil this develop-

¹ The authors use the term “insurance supervisor” to refer to the authority responsible for regulating the conduct of insurance business – both insurers and intermediaries – to protect policyholders’ interests in a particular jurisdiction.

ment function, authorities can mandate insurers to serve the low-income market, use moral suasion to impress upon insurers the need to widen their reach, or decide on a middle course. Supervisors increasingly realize that an enabling regulatory environment and better appreciation of the dynamics of the insurance market could help remove the perceived obstacles that normally discourage insurers from serving the low-income markets.

This chapter describes what supervisors have done, or can do, to support the growth of microinsurance by adapting their regulations. The chapter limits itself to the regulatory aspects of the insurance market.² The first section provides some background information on the regulatory environment for microinsurance. Section 2 summarizes the main regulatory barriers, which vary depending on whether one is creating a microinsurance institution or distributing microinsurance products. The third section describes the experiences in India, South Africa and the Philippines, where insurance authorities and policymakers have tried to make insurance markets more inclusive, but have chosen very different solutions. The last section summarizes the major challenges and lessons learned, and suggest possible next steps.

I Background

I.1 Inclusive financial systems

A key strategy for enhancing economic development and alleviating poverty is to make financial systems more inclusive, for example by improving access to savings and credit services for un- and under-served markets. In part, poverty stems from the fact that low-income households and markets do not have the same opportunities to finance investments, accumulate capital or protect assets (including human assets). The poor's heavy reliance on informal financial services – such as moneylenders, under-the-mattress savings and mutual assistance societies – can be inefficient and expensive, and may even exacerbate poverty.

An inclusive financial system makes insurance available to low-income persons. However, many commercial insurers and policymakers believe that providing insurance to the poor is the responsibility of the state. Although many governments have social protection programmes, the targeting of these schemes is often ineffective. The poorest segments do not always benefit from

² This chapter does not explore supervisory aspects of microinsurance, which are important but have not yet been sufficiently analysed since microinsurance is relatively new. It also does not consider non-insurance regulations or related policy areas that might affect microinsurance, such as the regulation of the healthcare industry or social protection policies, which are beyond the scope of this chapter.

the subsidy, while people who can afford insurance often find ways to access these benefits. In general, governments have made little effort to shift the burden of risk-pooling to market-led schemes; and the private sector (commercial insurers) seems to have little incentive to seek out this market segment.

1.2 The informality of microinsurance

In the absence of social protection and commercial insurance coverage, many informal microinsurance schemes have emerged, operating without an insurance licence. By staying small and keeping quiet, these informal providers hope that supervisors will not react. This has been the approach of many microfinance institutions that have provided insurance coverage to their members on a self-insurance basis. However, there are also large microinsurance schemes (*see Box 90*) outside the realm of prevailing insurance laws.

Another way to circumvent insurance regulations is to declare microinsurance services to be a non-pecuniary benefit. In many countries, healthcare facilities allow free or discounted access to healthcare in exchange for regular payments (premiums). Even though these schemes have a risk-pooling element, they are often called pre-payment schemes to disguise the fact that they are some form of insurance. Yet because the schemes are not licensed, the customers have little recourse if the hospital does not to keep its promises. Many credit unions or cooperatives also avoid insurance regulations by offering informal insurance as a member benefit.

Box 90

Informal insurance in South Africa

In South Africa, a number of schemes offer products that closely resemble life insurance. In the informal sector, there are an estimated 8 million members of informal burial societies contributing in excess of US\$1 billion per annum in “premiums” towards coverage for the risk of death. Some of these schemes are quite large. The Great North Burial Society, a registered Friendly Society, has more than 20,000 lives covered, but has no access to reinsurance as it is not a licensed insurer.

As the Insurance Amendment Act (2003) prohibits the use of the words insurance, funeral, burial or derivatives thereof in the description and marketing of these products, they go under different names, such as “bereavement benefits” or “death benefit plans”. It seems that the Amendment Act was intended to prohibit the underwriting of funeral cover without a short-term insurance licence, but legal loopholes continue to allow such informal insurance to be sold under different names.

Source: Adapted from Genesis Analytics, 2005.

1.3 The implications of the lack of a regulatory framework

Not having to comply with regulations has some advantages for microinsurers. Informal providers do not have to adhere to regulatory standards and do not have to comply with the supervisory burden (i.e. comprehensive reporting, internal controls and actuaries). They have more freedom to innovate and can potentially offer cheaper products, which may ultimately appear to benefit their clients.

However, the informal nature of these schemes also has serious drawbacks. The most obvious one is that it leaves policyholders unprotected against opportunistic behaviour. In the absence of supervision, customer protection is a serious concern. The long-term viability of these schemes is uncertain since their premiums may not have any actuarial basis, or their management may not be sufficiently skilled. Microinsurance schemes are also subject to greater covariant risk and are unlikely to have reinsurance protection. A catastrophe can pose a serious threat to the solvency of local microinsurance schemes. Finally, the growth of informal schemes can pose a threat to sustainability, e.g. when burial societies become larger, the effectiveness of the member-governance system is undermined and a separation is required between management and ownership. At this point, the burial society also accumulates substantial assets, which increases the risk of fraud or theft to a degree that member governance cannot control (Genesis Analytics, 2005).

The positive effects of providing microinsurance beyond the radar of insurance supervisors have to be weighed against its negative effects on institutions and markets, as well as on the economy. As far as the institutions are concerned, many microinsurance providers currently have no choice. If they could get a licence, they would have the chance to improve their operations, grow and attract investors. It is realistic to expect that many would opt to become a part of the formal insurance industry.³ As a result of regulatory barriers, existing and potential microinsurance providers have remained excluded. Consequently the market remains less developed – low-income segments are not protected, government budgets are not relieved, insurance markets are not inclusive, financial innovation is sluggish and deeper penetration of financial services does not take place.

However, formalization can also be accompanied by a number of problems for insurers targeting the low-income segment. One problem is that the social orientation of some microinsurers may fade away when they become licensed. This can create new problems, such as those experienced by ALMAO (*see Box 91*).

³ In India and Sri Lanka, microinsurers have lobbied for lower entry requirements, so far unsuccessfully.

Box 91

Formalization of ALMAO

ALMAO in Sri Lanka, which uses credit unions as its main distribution channel, changed from an informal scheme to become a regulated insurer in 2002. When subjected to regulation as a fully-fledged insurer, the organization felt compelled to change its product line. Instead of continuing to focus on the funeral policies and other simple, low-cost products it offered as an informal insurer, ALMAO introduced endowment policies that have not sold well, perhaps because the premiums are much higher than the target market was used to, and the marketing of these more complicated products required better-educated and trained staff in the credit unions. It is also possible that the professional insurance management brought in to run the new insurance company unintentionally steered the organization away from its core market, or did not consider the priorities of the credit unions and their members. The general difficulty of committing credit union staff to insurance marketing may also have increased because ALMAO became a more distant, commercial and professional organization.

Source: Adapted from Enarsson and Wirén, 2006.

1.4 Insurance supervisors and microinsurance

Some insurance supervisors are becoming more interested in and sensitive to the challenges and potential of microinsurance. In line with global efforts to increase the outreach of financial and insurance services, supervisors are increasingly mandated to facilitate their governments' efforts to relieve themselves of funding insurance and social protection schemes through public budgets, and transferring part of the basic safety net for low-income populations to the private sector. As a result, some supervisors support initiatives to make the insurance market more inclusive, so that formal insurance companies can take advantage of this new market opportunity and informal schemes can integrate into the formal insurance sector, as illustrated below in Section 3.

However, in general supervisors lack information on and experience with microinsurance and are unaware of alternative legal and regulatory regimes that encourage insurance for the poor. In some cases, policymakers believe that poor people do not want insurance or cannot honour financial obligations,⁴ and that they must therefore be covered by the state or through social

⁴ The experience of microfinance has shown just the opposite; often, loan default rates are much lower for the low-income market than for larger companies or the higher-income market.

security schemes. They do not as yet appreciate the role of microinsurance in financial sector development. Another widespread assumption is that existing insurance laws and regulations are non-discriminatory, which therefore ensures that low-income people have equal access to insurance – an assessment that does not stand up to scrutiny.

Even if supervisors have taken notice of microinsurance schemes, they do not see the necessity to react due to other priorities. They are often under pressure to focus on supervising commercial insurers that are a greater threat to the stability of the financial system, instead of licensing and supervising additional, often small, insurance providers that have a negligible market share, and which may require a completely different supervisory approach. Also, supervisors often do not know how they can fulfil their developmental role because innovative regulatory solutions for microinsurance remain scarce. Last but not least, in many emerging markets supervisors are often not interested in microinsurance because the insurance industry itself is still in an infant stage and they are under heavy pressure to regulate and supervise that properly.

The area of responsibility is an additional problem. Although insurance supervisors are responsible for implementing insurance regulations, microinsurance providers often operate under other authorities, such as a cooperative commission, the NGO Bureau or the health ministry. Consequently, these schemes are not seen as part of the insurance sector, even though they clearly provide insurance services. Moreover, the people responsible for supervising them generally do not have the expertise and systems to perform such supervision (*see Box 92*).

Box 92

Insurance cooperatives in Malawi

In Malawi, the Supervision Department of the Reserve Bank of Malawi is entrusted with the task of regulating and supervising the insurance sector. The Department has limited resources; its main supervisory approach is to scrutinize reports from insurance companies. It is aware that the credit union association Malawian Union of Savings and Credit Cooperatives (MUSCCO) provides life insurance to more than 55,000 low-income persons, but claims that since MUSCCO is registered as a cooperative, it does not have the jurisdiction to support or control its activities. However, the Registrar of Cooperatives under which MUSCCO operates lacks resources, skills and interest to supervise insurance activities.

Source: Adapted from Enarsson and Wirén, 2005.

The very existence of informal insurance suggests that existing laws and regulations in some ways impede the inclusiveness of the formal insurance market. The question for insurance authorities and policymakers is: what should they do to remedy this situation? Leach (2005) identifies the balancing of stability and access as a regulator's dilemma.⁵ Should they try to formalize informal schemes to enhance consumer protection, which could stretch supervisors' resources to the breaking point? Should they shut down informal schemes since they are essentially illegal? If informal schemes are allowed to operate, how should they determine the threshold that triggers regulatory intervention? Or is there some middle ground that could expand access to insurance with some degree of consumer protection?

2 Barriers in existing regulatory frameworks

There are conflicting views among insurance supervisors on the extent to which regulations should be adapted to the specific characteristics of microinsurance. According to a survey conducted by the IAIS, the majority of supervisors believe that the existing laws and regulations in their jurisdictions do not discourage microinsurance. However, very few jurisdictions have laws or regulations adapted to encourage microinsurance. This section considers the regulatory barriers that limit the creation of microinsurance companies as well as those that impede the proliferation of microinsurance products.

2.1 Regulatory barriers to creating formal microinsurance institutions⁶

A cautious approach treating microinsurance on a par with commercial life and non-life insurance actually discourages the development of microinsurance. Such a "one-size fits-all" policy makes the job of the supervisor easier, but lacks a convincing rationale. The insurance requirements described below are barriers to microinsurance formalization.

Where there is only one institutional option, **high capital requirements** can impede the establishment of regulated insurance institutions dedicated to the low-income market since amassing the volume of small policies required to generate a return on such an investment could take years, if it ever occurred at all. Furthermore, imposing high capital requirements designed to

⁵ Leach (2005) identifies three dilemmas for financial sector regulators: 1) the trade-offs between stability and access (which only partly relates to the issue of regulating informal providers), 2) managing innovation and 3) handling international pressure to conform to standards and codes.

⁶ Formal microinsurance entities can be either companies (first-tier institutions) or member-based institutions under a lower tier.

protect the financial system seems inappropriate for such small policies – a capital sledgehammer to crack a solvency nut. The current trend toward raising capital requirements in many countries may force existing microinsurers to close down (*see Box 93*). Their existing policyholders, in the absence of alternative sources of coverage, risk having no protection in the future.

Box 93

Capital requirements in Peru

In Peru, the insurance law issued in 1993 did not promote insurance products for the low-income market. Higher capital requirements were introduced and caused some insurance companies to merge, while others left the market altogether. From October 1994, SEGUROSCOOP, a low- and middle-income segment insurer, had to cease operating as an insurance company. However, it found a solution: it formed a new company called ServiPerú that offered social security services, i.e. health and funeral services. It also created a subsidiary insurance brokerage and transferred its insurance portfolio to an insurer. As an insurance broker, ServiPerú is supervised by the Banking and Insurance Superintendence. As far as the social security services are concerned, ServiPerú is under the control of the Supervisory Commission for Enterprises and Securities (not governed by the insurance law). Although not an ideal solution, the former insurer found a new way to operate (new company structure, new products, and new distribution channel), stayed in the market and continued to serve its clients.

Source: Adapted from Rodriguez and Miranda, 2004.

There are a number of other requirements in insurance laws and regulations that prevent microinsurers from getting a licence, such as the high **requirements for key management**. Highly-qualified insurance managers are unlikely to opt to lead a microinsurance organization, which generally offers a lower salary and fewer career options than a commercial insurer. Obviously it is necessary to have qualified people running the company, but should the qualifications be relaxed for microinsurers?

Complex reporting requirements can make the cost of management and administration prohibitively expensive for small microinsurance operators. If reporting and disclosure requirements, originally designed for large insurance companies with complex structures, are imposed on microinsurers with simple procedures, costs will rise. Similarly, the **requirement to have an actuarial review** can be expensive and difficult to fulfil in some jurisdictions. This regulatory burden, perhaps coupled with a **premium tax**, adds to the cost of the product and leads to a reduced level of access for the poor.

These aspects need to be analysed to appreciate where entry barriers can be lowered to promote microinsurance. Certainly, supervisors appear justified in not licensing insurance entities with weak management and low capital. However, it is questionable whether organizations which are often locally-based and oriented towards the low-income market should be denied a licence on the basis of requirements that are neither relevant nor appropriate for the types of services that they offer. This is particularly true for mutuals and friendly societies, for which a long legal tradition exists of requiring no capital at all since risk is borne by the membership.⁷

Without a licence, the microinsurer is trapped in a vicious circle: no access to sources of additional capital or reinsurance, which ultimately means no growth for a prudent operator. If these schemes cannot grow, then it will be difficult for them to achieve economies of scale and extend coverage to the vast unserved market. In such an environment, policyholders are not protected⁸ and the institutional learning curve is not inspired by external control (supervision) and high standards (regulation). The only advantage that supervisors enjoy is that they do not have to deal with many small insurance schemes.

2.2

Regulatory barriers to distributing microinsurance products

As mentioned in numerous chapters, one approach to expanding microinsurance services is for a regulated insurance company to offer a product line that reaches the low-income market through alternative distribution mechanisms, including community organizations, banks, retailers, cell phone companies and others. However, regulatory barriers can also inhibit the use of these distribution channels even though they might be effective in reaching low-income markets. Supervisors need to monitor trends to ensure that regulation is not restraining the innovation by distribution channels in a way that is detrimental to market development (Leach, 2005).

Microfinance institutions (MFIs) are a key distribution channel for microinsurance because they already engage in financial transactions with the low-income market. However, in some jurisdictions, MFIs – and other institutions that work closely with the poor – cannot distribute insurance without conforming to stringent **licensing requirements for agents or brokers**. For example, the requirement that an agent has to be a private person may

⁷ This is the case in Belgium, France, Germany, Ireland, Japan, United Kingdom and United States (practically all states), as well as Belize, India, Mali, Martinique and South Africa among others.

⁸ Commercial insurance regulations often stipulate cumbersome practices that are inappropriate for low-income customers, who may be illiterate and understand little of insurance. This result is ironic since this target market requires even more consumer protection.

not allow MFIs to sell insurance. The requirement for specialized staff to sell insurance undermines the efficiencies that are possible by selling insurance through loan officers and tellers. Some jurisdictions prohibit lending organizations from selling insurance altogether, citing conflict of interest.

Furthermore, the training requirements to become a licensed agent may be excessive given the simplicity of microinsurance products. Should a poor housewife who wants to sell US\$500 endowment policies to her friends and neighbours have to go through 100 hours-worth of training? In some jurisdictions, the licensing requirements for agents are not strictly enforced, allowing MFIs and microinsurers to sell insurance, albeit in a potentially vulnerable legal situation (*see Box 94*).

Box 94

Requirements for agents and brokers

In the **Philippines**, the Insurance Commissioner (IC) licenses agents that have fulfilled certain criteria (e.g. payment of a registration fee, passing an exam, and no criminal record). An agent has to be a private person. However, several MFIs in the Philippines collaborate with Cocolife to insure more than 300,000 poor households – although these MFIs are not registered as agents. They sell Cocolife’s products, but do not receive a commission. Instead they load the net premium charged with an administration fee that is paid by the client to the MFI at the start of each loan (Leftley, 2005).

AIG Uganda has a partnership with 26 MFIs in three countries to cover over 1.6 million lives. In Uganda, any individual selling insurance as an employee of an MFI would technically need to be licensed, though in practice none are. As a consequence, the MFIs’ credit officers often lack the skills to sell insurance and to advise customers (McCord et al., 2005a).

In **Bangladesh**, insurance agents also need to be licensed. This may help to ensure a minimum level of agent quality; however, it may also make it difficult to serve the rural poor. Delta Life, for example, certifies the agents for its mainstream products that target middle- and higher-income persons in urban areas. However, it calls its microinsurance agents “organizers” to avoid licensing requirements. Another complication is that agents are eligible to continue to earn commission on renewal premiums even after they have left the insurance business, which creates additional administrative complications when dealing with hundreds of thousands of very small policies, and thousands of organizers (McCord and Churchill, 2005).

Restrictions on the amount of agency commission that can be offered by an insurer to the agent may also hinder microinsurance provision. The justification behind this clause is to protect the life fund from becoming depleted due to expensive distribution structures. However, such clauses

may create a problem for microinsurers, since low-income markets are more expensive to serve and may justify a higher cost structure.

Where microinsurers offer long-term policies, the prescribed commission structure may not be appropriate. For example, the commissions approved by the Insurance Board of Sri Lanka (IBSL) pay 30 per cent in the first year, but drop off to 5 per cent after Year 4. In an environment where banking or postal payment systems are not widely used, the agent is responsible for collecting premiums, often by going door-to-door. Given the required commission structure, Enarsson and Wirén (2006) argue that the retention rate is likely to go down drastically when the agent's commission is reduced since it is much more attractive to recruit new clients than to collect premiums from old ones. Therefore, one can expect a high lapse rate that will undermine the credibility of insurance among the low-income market.

Another product-related regulatory barrier is the fact that insurance companies cannot underwrite **composite business**, even though it might be an appropriate product structure for the low-income market.⁹ In many jurisdictions, licensing requirements do not allow the formation of composite insurance companies, but require separate companies for life (long-term) and non-life (short-term) business. The protection achieved by not mixing long-term and short-term liabilities is justified for commercial lines of insurance or for policies with large sums insured. However, the same logic does not apply to microinsurance, where policies generally do not go beyond five-year terms, and the vast majority are for one year or less (*see Box 95*).

Box 95

AIG Uganda

AIG Uganda covers many microfinance borrowers, but with a non-life licence, it can only provide accidental death and disability insurance. However, the poor do not differentiate between different types of death. It does not matter whether one dies in a car accident, or from malaria or a heart attack. These microfinance clients want protection regardless of the cause of death. AIG Uganda cannot legally provide life coverage even though most terms are only four or six months (corresponding to the MFIs' loan terms).

Source: Adapted from McCord et al., 2005a.

As regards **suitable types of products for low-income segments**, it appears that group products are the most appropriate. It is unclear whether endowment policies should be recommended for microinsurance clients at all. Endowment policies require a savings discipline that low-income segments often do not have due to fluctuations in their household cash flow,

⁹ Arguments for and against composite or basket covers are presented in Chapter 3.1.

which leads to high lapse rates (*see Chapter 2.2*). Furthermore, endowments may actually be a poor form of savings for these households due to the insurer's high cost structure and taxation requirements.¹⁰

Policy wording requirements are sometimes unsuitable for low-income clients, who are often illiterate (even educated people cannot understand most insurance contracts!). Insurance policies for the poor should be written in very simple language without legalese, so as to ensure that the terms and conditions are easily understood.

In jurisdictions where a **tariff regime** is in vogue, the rates, policies, terms and conditions are standardized either through industry practice or regulation. Although such a regime may appear to have several advantages, it can also hamper innovation and competition, which are particularly important for microinsurance.

2.3 Macro-level barriers

There are other barriers related to policy and legal framework, the implications of which are not yet properly understood, but which are nevertheless worth identifying. Firstly, some jurisdictions may face **over-regulation of the insurance sector in general**. For example, some countries restrict foreign investments in the insurance industry, which makes it difficult to transfer know-how to make delivery of microinsurance products and services more effective and efficient. Furthermore, protectionist policies may require the purchase of over-priced and/or low-quality domestic reinsurance.

Secondly, **overlapping regulations** can create complications for microinsurance design and delivery. For example, in South Africa, a large burial society needs to have a legal personality (registered with the Department of Trade and Industry), be registered as an insurer (financial services regulator), may be supervised by an apex or self-regulatory body,¹¹ and if providing an in-kind benefit (funeral services), be regulated by the Department of Health.

Thirdly, when **governments maintain or launch subsidized insurance schemes**, they do not usually consider whether these schemes could be offered via market mechanisms. An analysis of whether these schemes could be maintained without a subsidy is not carried out. Instead of popularizing the existing schemes, such government action undermines microinsurance

¹⁰ For example, low-income households are often tax-exempt, implicitly or explicitly, while the insurance companies pay corporate taxes on the investment returns, and therefore the return to the policyholder is net of tax.

¹¹ Among mutual institutions, apex organizations often play an important role as regulators, not only in insurance but also in the savings and loans market.

providers as policyholders migrate to the subsidized scheme. As a result, the strains on budgetary resources remain and the subsidies are often not employed or targeted properly.

3 Country experiences – preliminary insights

Despite the wide-ranging and complicated regulatory barriers, there are solutions, some of which are actually being implemented. Several countries have adapted their regulatory frameworks to microinsurance.¹² This section describes the experiences in India, South Africa and the Philippines, which employ different strategies to overcome regulatory obstacles to the expansion of microinsurance.

3.1 India

India's Insurance Regulatory and Development Authority (IRDA) has taken a proactive approach in promoting microinsurance by obliging insurance companies to serve the poor in the hope that this forced familiarity will help insurers see the potential of the low-income market. In what is essentially a quota system, all insurance companies are obliged to underwrite business in pre-defined rural areas¹³ and in the social sectors.¹⁴

The evidence from these quota requirements is mixed. Failure to attain the targets has resulted in financial penalties for some insurers, and repeated violations could cause an insurer to lose its licence. Some insurers perceive the requirements as a cost of doing business and dump poorly-serviced policies on the market. Other insurers like ICICI-Lombard and Tata-AIG now consider the poor to be a viable market opportunity and have voluntarily exceeded their quotas, so the forced familiarity approach could be paying off. The extent to which this quota system is replicable in other countries remains doubtful since it is not in line with market-led policies for financial systems development.

¹² India, Morocco, Trinidad & Tobago, the Philippines and Japan are among the few countries where regulations have been adapted to microinsurance. South Africa has adaptations in progress.

¹³ Rural areas are defined by the Census of India as places which simultaneously satisfy or are expected to satisfy the following criteria: (i) a minimum population of 5,000, (ii) at least 25 per cent of the male working population engaged in agricultural economic pursuits and (iii) a population density of at least 400 per square kilometre (1,000 per square mile). In these areas, life insurance must account for 5 per cent of total policies in Year 1, rising to 16 per cent from Year 5 onwards and general insurance must be 2 per cent of total gross premium written in Year 1, rising to 5 per cent from Year 3 onwards (IRDA, 2002).

¹⁴ The social sectors are defined as "unorganized workers, economically vulnerable or backward classes in urban and rural areas". Here, each insurer has to maintain at least 5,000 policies in Year 1 rising to 20,000 in Year 5, for both life and general insurance. This is regardless of the size of operations (IRDA, 2002).

To assist insurance companies in complying with these requirements, the IRDA has recently issued new microinsurance regulations to actively facilitate partnerships between regulated and unregulated entities (IRDA, 2005). These new requirements are designed to ensure that risk carriers remain supervised, but allow them to explore different distribution channels to extend insurance to the poor.

The regulation creates a new intermediary, the microinsurance agent, which can be an NGO, MFI or other community organization appointed by an insurer to distribute microinsurance through specified persons. Microinsurance agents enter into a “deed of agreement” with the insurer. They abide by the code of conduct defined by the IRDA and attend 25 hours of training (down from 100 hours for conventional insurance agents) in the local language at the expense of the insurer. There is no qualifying examination, as is the case with ordinary insurance agents. A cap is put on commission, between 10 and 20 per cent of premiums per year according to type and mode of insurance payment, which is in excess of what conventional agents would normally earn.

The new regulation also allows for the bundling of life and non-life elements in one single product provided there is clear separation of premium and risk at the insurers’ end. Parameters of the microinsurance product are also regulated (see Table 48) and are subject to actuarial sign-off and “file and use” requirements. Products beyond the prescribed sum insured do not qualify as microinsurance and therefore the licensed agents would require more expertise.

Table 48

Definition of microinsurance in India

<i>Product line insured (Rs.)</i>	<i>Minimum sum of cover (years)</i>	<i>Maximum sum</i>	<i>Term insured (Rs.)</i>
Life	5 000 (US\$113) ¹⁵	50 000 (US\$1 130)	5
Non-life	5 000 per asset	30 000 (US\$678)	
Health	5 000	30 000	1
Personal accident	10 000 (US\$226)	50 000	1

This regulation is seen as an important step towards expanding microinsurance in India. However, critics argue that this regulation is very narrow because it focuses on just one approach, the partner-agent model. They also argue that product details should not be centrally regulated. Since the high-minimum capital requirement for an insurance company (US\$22 million) has not been lowered, there is perhaps insufficient competition among risk carriers. In response to this last point, the supervisor has recommended to the

¹⁵ US\$1 = Rs. 44.25 (Indian Rupee)

government that the capital requirements for health insurance be reduced by half to increase the number of health microinsurance operators.

The new microinsurance regulations show one path to enhancing distribution efficiency, by a partial relaxation of training and remuneration norms and by the bundling of products, without compromising the risk-taking ability of a commercial insurer.

3.2 South Africa (SA)

Microinsurance in SA has been undertaken for many years, just not under that name. The most common form of microinsurance is funeral insurance (often offered under an Assistance Business Licence in SA), which is “a life policy in respect of which the aggregate value of the policy benefits, other than an annuity, to be provided....does not exceed R10,000 (US\$1,500)¹⁶ or another maximum amount prescribed by the Minister”. The Assistance Business Licence then allows uncapped commissions. The Friendly Society Act allows for cover up to R5,000 (US\$750). All other funeral insurance providers have to register under the Long-Term Insurance Act, which requires minimum capital of ZAR 10 million (US\$1.5 million). They can offer funeral insurance for any sum assured, but their commissions are capped (Genesis Analytics, 2005).

Most microinsurance in South Africa is generated by the funeral industry, which has been in the low-income market for some time, but the market is still under-served. The question is how to expand funeral services in a sustainable manner. In this regard, the SA Financial Services Board (FSB), the non-bank regulator and supervisor, faces a significant dilemma. A large proportion of funeral insurance is effectively unregulated since the main providers – burial societies and funeral parlours – are registered under the Friendly Societies Act. The supervisor is concerned about the continued viability and sustainability of this model, and the ability of existing providers to manage their risks in the future.¹⁷ In the event of failure, the insurance supervisor, as well as the insurance industry, would face a reputation risk and market confidence could be devastated. Instead of being reactive, the supervisor, the government and the existing industry are considering proactive steps.

South African supervisors have not intervened as directly as their India counterparts to legalize and promote microinsurance. Rather, they rely on

¹⁶ US\$1 = R6.65 (South African Rand)

¹⁷ Besides revealing the significant scale of burial societies in South Africa (see Box 90), the FinScope Africa surveys of financial services (www.finscopeafrica.com) indicate that informal mechanisms are not ideal: 9 per cent run out of money to pay claims and 4 per cent suffer from fraud. Default rates at these levels among formal insurers may be seen by regulators as a systemic problem, particularly because of the large numbers of people affected (Genesis Analytics, 2005).

the Financial Sector Charter,¹⁸ whereby all financial service providers have agreed to voluntarily serve the low-income market. Consequently, the SA insurance industry has experienced a huge wave of innovation as insurers experiment with new delivery channels to reach the poor, including joint ventures and partnerships with retailers (*see Chapter 4.6*). It is too early to assess whether the new wave of innovation will succeed. At present, less than 1 per cent of SA's poorest 60 per cent have short-term insurance (i.e. non-life), which has to be raised to 6 per cent if the Charter's targets are to be met. To assist companies in meeting the targets, the FSB is responsible for promoting consumer education. Therefore, the FSB has a massive role to play in terms of facilitating, funding, monitoring and coordinating better consumer education.

At present, there is an initiative to create a more level playing field and to remove burial societies and funeral parlours from the Friendly Societies Act to a parallel Cooperatives Act which is more suitable in the SA context. The development of this new tier will comprise a dedicated funeral insurance licence available to all players in the market, with reduced entry and compliance requirements. The new tier should be accessible to both member-based and commercial insurers. Small, member-based burial societies should come under the new Cooperative Bill.

3.3 Philippines

In the Philippines, the insurance supervisor has created a two-tier system, similar to the tiered regulatory environments that have emerged for microfinance. To create a life insurance company under the first tier, it takes Php 50 million (about US\$1 million) and for non-life Php 100 million (US\$2 million).¹⁹ The Insurance Commission (IC) of the Philippines plans to increase the minimum capital requirement for all new insurance players.

The second tier comprises mutual benefit associations (MBA), an institutional form created by the IC under the ambit of the insurance law. Although most MBAs are small and unregistered, once they become significant enough to be “noticed” in terms of volumes and membership numbers, they need to be registered, i.e. licensed by the Commissioner.

¹⁸ The Financial Sector Charter (2003) in South Africa was originally conceived as a transformational blueprint for the financial services industry, i.e. de-racializing the financial sector in terms of its – hitherto predominantly white – ownership, employment and procurement practices; however, it also includes very specific targets for an improvement in financial access. Signatories of the Charter include government, industry bodies and representatives of labour and civil society. In specific terms, banks and insurers have committed to provide certain products and services to lower-income people by 2008.

¹⁹ US\$1 = 52.87 Php (Philippine Peso)

According to the Mutual Benefit Associations Act,²⁰ such associations are subject to supervision and need to have access to an actuary. An MBA must deposit US\$182 as initial capital and continue to contribute to a guarantee fund at least 10 per cent of its assets, up to the minimum capital required for a fully fledged insurance company. MBA licensing and supervision provides some protection for members since the supervision reduces the scheme's vulnerability to fraud and mismanagement. The IC has established a special MBA unit to supervise them.²¹ Nonetheless, in practice, it does not aggressively challenge non-registered MBAs due to its limited supervisory capacity, which raises doubts as to the degree of consumer protection under the current arrangements. Agents of MBAs do not require licences.

One problem with this arrangement is the high income-tax differences between commercial insurance companies and these second-tier institutions, which can be a deterrent to conversion into a first-tier entity. For example, CARD MBA, which provided life insurance to more than 600,000 poor Filipinos in 2004, originally planned to become a fully fledged insurance company. This plan has not progressed, however, due to the high tax burden on insurance companies, even though CARD MBA would have a number of interesting business opportunities as a first-tier insurer.

Although this tax issue is not directly in the realm of insurance supervisors, they are in a position to provide relevant input and convey it to the policymakers. In the present situation, when governments in many countries are looking to promote alternative market-based mechanisms to provide protection for the lives, health and assets of their population, policymakers may find merit in such proposals.

Some MBAs are registered as such to take advantage of more favourable tax conditions (regulatory arbitrage) and some MBAs are not in the best of financial health, possibly due to mismanagement, among other reasons. In recognition of these problems, the IC plans to adjust the MBA regulation in the near future.

4 Conclusions

The starting point for creating inclusive insurance markets is for supervisors to have a mandate to do so. If insurance supervisors are to comply with this mandate and take their market development responsibilities seriously, they need instructions from policymakers to the effect that this is indeed a priority. Such instructions make sense, given the role of insurance in achieving the

²⁰ Chapter VII of the Insurance Act (Sections 390–409).

²¹ In 2001, 18 out of the 32 licensed MBAs (56 per cent) were inspected on-site.

Millennium Development Goals (*see Chapter 1.1*) and the limited resources available for publicly-sponsored social protection benefits (*see Chapter 1.3*).

The major challenge for supervisors is to create an enabling environment for outreach and sustainability of the growing microinsurance market. From the policyholder's perspective, supervisors need to guarantee that the increasing number of semi- or informal microinsurance schemes fulfil their obligations to their members. The protection of poor people's scarce funds is a critical concern.

It is quite difficult to provide this consumer protection while at the same time encouraging innovative solutions to respond to the insurance needs of low-income households. Adjustments to regulatory frameworks are often perceived as being in conflict with prudential principles and risk creating distortions in the market place. Therefore, supervisors have to find a balance that promotes inclusion – which means extending insurance to the huge low-income market while protecting their investments and confidence – without putting an undue burden on supervisors. This is not an easy task.

Since high capital requirements are inappropriate for small microinsurance policies, one solution which needs to be further explored is the risk-based capital (RBC) approach. RBC represents an amount of capital that a company should hold to protect customers against adverse developments based on an assessment of risks. It is typically calculated by applying factors to accounting aggregates that represent various risks to which a company is exposed. Risk-based supervision has become recognized as an international standard, endorsed by the IAIS and the developed market supervisors.

Each jurisdiction has its specific features and there is no one solution that fits all. This is illustrated in the examples from India, South Africa and the Philippines, where each country has adopted a different approach. India compels insurers to serve the poor and has made some critical regulatory adjustments by reforming its broker/agent regulation, which may be the easiest way to stimulate the increased provision of microinsurance. South Africa, on its way to a new framework for microinsurance, is cautiously approaching its enormous informal insurance industry. The supervisor wants to extend consumer protection to those who have informal insurance, but does not want to regulate the schemes out of existence. The solution found in the Philippines is to build on the strength of mutual schemes. The model of the guarantee fund, tied to volumes and not requiring much initial capital, is an appropriate mechanism for providing consumer protection for these second-tier providers.

The revision of agent and broker licensing requirements could be the fastest and easiest way of stimulating increased provision of insurance services, while the creation of a new tier of institutions might be a major step for-

ward, but could require some time and effort. In addition, the emergence of third-party administrators could be important, since microinsurance is a high-volume, low-margin business that requires considerable administrative expertise. It is also useful to consider alternative distribution channels; retailers and cell phone companies – any organization that engages in financial transactions with the low-income market – could distribute microinsurance.

There should be a coherent, principles-based regulatory framework to take into account the different institutional requirements for microinsurance. Such a framework does not necessarily mean a separate law for microinsurance, as in the case of India. It could also comprise amendments to the insurance act, as in the Philippines. Rather than shoehorning all insurers into one common set of regulations, this framework approach requires differentiated rules and regulations for different provider models. In other words, special institutional options for microinsurance are likely to be more effective in enhancing the inclusiveness of the insurance industry than the standard regulation with a single tier.

Microinsurance promotion implies that policymakers and supervisors take concrete steps, while understanding that incorporating microinsurance schemes into the regulated sphere imposes costs on supervisors as well as on the microinsurers, which may have to be passed on to the policyholders. In addition, one has to look critically at the threat that the formalization of informal schemes may result in a loss of social orientation.²²

Good supervision requires insurance-specific technical competence. It is certainly not appropriate to delegate responsibility to other government authorities. In the same line, the capacity of insurance supervisors is a serious consideration. It is unrealistic to promote adjustments to the regulatory environment that will result in an increase in regulated insurers, some of which will need different supervisory approaches, without building up the capacity and resources of insurance supervisors.

A critical question is how to react to small schemes that are not (yet) able to adopt the commercial orientation required for a formalized institution. It is important to define a threshold where formalization is required and where regulation needs to be imposed (Genesis Analytics, 2005). Microinsurance operations up to this threshold would then be exempted from supervision. However, once the threshold is crossed, such entities need to be formally licensed.

²² In microfinance, the data show that the correlation between formalization and mission drift is much weaker than suspected, and was never considered to be a serious problem. This might be partly related to the fact that finding “real commercial” owners was, in most cases, not an urgent necessity for the transforming MFIs due to the many development-oriented investors available.

An intermediate step for smaller microinsurance providers that are too large to operate outside the regulatory radar, but still too weak to apply for a licence for fully fledged insurers, could be self-regulation (market-conduct standards) organized by an apex body. Self-regulation may help the industry to some extent, but can never free insurance supervisors from their responsibilities. This approach would only be feasible in countries with a significant number of providers (Genesis Analytics, 2005).

Microinsurance straddles the boundary between government-provided social protection and market interventions. Consequently, intensive stakeholder dialogue is required to ensure compatibility and cohesiveness of both private and public policies. For example, an insight into the pricing mechanism of insurance schemes subsidized by governments could provide a benchmark showing how such schemes would have worked in the absence of subsidy. In addition, it also provides evidence on the merits of public-private partnerships for ensuring better servicing, lowering costs and subsidies and directing subsidies to the most vulnerable segment of the population. Clear rules need to be defined in terms of accounting and solvency norms to segregate government-subsidized products in an insurer's portfolio.

Finally, for regulatory adaptations to work, there needs to be a significant investment in education at many levels. Policymakers and supervisors have to understand the risks and potential of microinsurance, and therefore know-how transfer and dialogue are primary concerns. Donors and other promoters are also learning and have to be prepared to finance and technically assist supervisors as well as microinsurance providers. Finally, the customers who demand microinsurance services are not well-educated; governments and donors have to assume a role in this area. These challenges have to be dealt with alongside the regulatory and supervision aspects.

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Protection against risks is a citizen's right. Therefore, it is a responsibility of the state to use all possible means to deliver this public good and to create an environment in which equitable access to social protection systems is promoted (ILO, 2002c).

Governments can play different roles when trying to fulfil this responsibility. Firstly, as discussed in Chapter 1.3, governments can provide social protection, such as universal healthcare, workers' disability benefits and old-age pensions. However, the fiscal income of governments is constrained. In many developing nations, no more than 20 per cent of the active population is usually included in regular social security systems (ILO, 2000). Many governments are currently unable to provide these fundamental services to the vast majority of their citizens.

Secondly, governments are responsible for regulating and supervising the insurance industry, which provides valuable protection to the country's businesses and citizens, especially to those able to pay for it. If the government is unable to provide an appropriate degree of social protection itself, it should at least create an environment in which the market can extend protection systems to under-served segments. As described in the previous chapter, adjustments to insurance law and regulations may do much to enable commercial insurers to serve the low-income market.

However, even in a regulatory environment conducive to microinsurance development, market forces alone will not solve the problem of insufficient social protection coverage. On a purely commercial basis, microinsurance – with its small transactions, low premium income, relatively high administrative costs and hard-to-reach target market – is not particularly attractive to most insurance companies. Where coverage and quality of formal social security schemes are limited, and where insurance companies are not extending services to the poor, governments need to explore other options to increase social protection coverage.

This leads to a third approach, where governments play the role of facilitators to help overcome market imperfections by promoting microinsurance through a variety of institutional options. In this promotional role, governments could even use their finite resources to promote additional investments from the private sector to provide protection. This chapter describes this third function and illustrates ways in which governments can promote microinsurance.

I Policy-making, participation and consensus-building

If a government considers social protection a policy priority and if it feels microinsurance can supplement other aspects of a comprehensive social protection scheme, it may decide to actively promote this approach. Before doing so, it is likely to weigh the potential of microinsurance against its limitations. Governments should involve all key stakeholders at an early stage in this process of discussing and formulating policies.

Microinsurance is neither the only, nor necessarily the best possible alternative to protect the target population against the most significant risks. Most schemes reach only a fraction of the population and do not solve the problem of access for the poorest and most vulnerable groups, who cannot afford contributions and have protection needs beyond what microinsurance can offer. It would, therefore, be unrealistic to assume that microinsurance could cover everyone not covered by existing formal schemes. Yet it can play a contributing role; what exactly that role is will depend on the political process.

Decisions on public policies – particularly in the context of social matters – are essentially political, as they involve a number of fundamental, yet subjective questions that need to be explicitly addressed in a comprehensive public policy on social protection. What is, for example, the desired level of solidarity? A first step in the formulation of a policy on microinsurance is for the government to facilitate a participatory process that assesses whether the nation's social goals may be effectively and sustainably pursued through microinsurance. In this context, the extent of a government's commitment to its social objectives is important in determining whether and how it should become involved in microinsurance. A national policy framework should define the role of microinsurers in the larger context as well as the particular roles of the government and other stakeholders.

It is crucial to involve all key stakeholders in the process of formulating policies if they are to be widely accepted and broadly supported by the majority of the population. The stakeholders include civil society groups (e.g. religious bodies, NGOs), cooperative-type self-help organizations and

their apex bodies, and commercial domestic and international insurers. Other important players in microinsurance include employers' and workers' organizations, service providers, professional associations and bi- and multilateral development partners.

Success in promoting microinsurance depends on close partnerships between all stakeholders; however, certain activities can only be provided by the state, such as the creation of legal frameworks and the provision of services that no commercial player would be able or willing to offer. Public-private partnerships (PPPs) may have particular relevance where national resources and know-how are limited. For example, one of the largest insurance companies in the world, Allianz AG, has teamed up with GTZ and UNDP to develop microinsurance products in India and Indonesia.

The overall process of participatory policy-making needs to be facilitated by the government, which requires the political will to do so. In this context, a technical problem can be that workers in the informal economy are often too insufficiently organized to communicate their needs to the government (Carrin, 2002). Politically, it may be difficult to arrive at a consensus on the degree of solidarity and redistribution required to extend social protection coverage to the whole population. It takes a lot of political will to extend coverage to the poorest since the issue of reducing their vulnerability competes with other priorities.

Among the key issues to be decided by stakeholders is the definition of the microinsurance concept, for which there is a range of options. For example, which delivery model(s) should be given priority – cooperative-type self-help organizations, partner-agent models, community-based insurance schemes, direct sales models or a mixture of some or all models? Other questions are those relating to compulsory or voluntary membership, the degree of co-financing or premium subsidization, and the admission of index-based risk management schemes or derivatives (e.g. weather-index-based insurance schemes).

Depending on the specific circumstances in a country and after consultations with major stakeholders, the government needs to choose the most feasible options for the promotion of microinsurance. Careful evaluation allows the prioritization of possible instruments and ensures the selection of those with the highest potential impact on the nation's social objectives relative to their cost. The various tools or options at the government's disposal include: (a) creating an enabling environment, (b) strengthening institutions and (c) providing financial assistance.

2 Creating an enabling environment

Although often associated with the legal and regulatory framework, an enabling environment actually encompasses a broad range of areas. In fact, virtually every government activity, from law-making to the provision of public services (e.g. basic health, basic education, physical security and labour market policies that promote decent work) could be seen as contributing to an enabling environment. By identifying possible environmental or infrastructure obstacles that impede the development and expansion of microinsurance, governments may be able to make adjustments through limited investments that could significantly increase the availability and quality of insurance to the poor.

2.1 Legal and regulatory framework

Many microinsurance providers operate outside the insurance laws where neither the interests nor the funds of consumers receive adequate protection. As described in the previous chapter, a well-designed regulatory framework is a major factor in the effective and efficient provision of microinsurance services.

Apart from a specific law for microinsurance institutions, a number of additional legal regulations influence the creation, operation and expansion of microinsurance schemes:

- The regulatory framework for microfinance institutions (MFIs) that may act as brokers or delivery channels
- Laws for other types of institution such as cooperatives
- The entire legal framework for the insurance market including reinsurance
- Government accounting regulations aimed at preventing fiscal irregularities
- Tax laws

to mention just a few.

Policymakers have to ensure the consistency of policies, laws and regulations relating to microinsurance. Thus, a systemic approach to policy-making is required.

The regulatory framework determines, for example, whether non-profit organizations, cooperatives and community-based microinsurers are formally allowed to enter the market. Moreover, it defines the scope for private initiative, e.g. whether commercial insurers are given additional, mandatory responsibilities through a quota system for the poor as in India. As an alter-

native to forcing insurers to enter the low-income market, they could be encouraged to do so through incentives, for example by offering tax advantages to private-sector insurers that offer products to the poor. In such a situation, it is important to recognize that the low-income market may require a different type of consumer protection (*see Box 96*). In addition, it may be necessary to explore ways of extending consumer protection to policyholders in informal insurance schemes.

Box 96

The Insurance Ombudsman Sri Lanka

The new office of the Insurance Ombudsman in Sri Lanka was opened on 1 February 2005. The positive experiences from the Financial Ombudsman Scheme in Sri Lanka led to the establishment of this new office. The objective of the Insurance Ombudsman is the satisfactory settlement of complaints by and disputes with policyholders of insurance companies covered by the scheme, which include ALMAO (All Lanka Mutual Assurance Organization) now that it is a regulated insurance company. The Ombudsman has the power to make monetary awards that are binding for the participating insurance institutions.

Apart from the primary function of attending to complaints, the Ombudsman engages in efforts to create greater awareness about insurance among people in Sri Lanka. Given ALMAO's outreach to the low-income market, both the social marketing and the complaint-processing approaches will need to be adapted to the characteristics of ALMAO's policyholders.

Source: Adapted from Enarsson and Wirén, 2006.

2.2 Risk prevention and social marketing

Governments can play a key role in risk prevention and reduction. At a macro level, preventive policies to mitigate the impact of events such as economic crises, natural disasters and social conflicts can create a stable environment in which microinsurance schemes can thrive. In addition, risk-reduction activities such as improved flood protection systems, improved sanitation, preventive healthcare and effective monitoring of communicable diseases can significantly lower risk and, therefore, claims expenses, thus reducing insurance premiums and making insurance products more affordable for the poor (*see Chapter 3.9*). Naturally, these are initiatives that governments would want to initiate for citizens in general, not just to bolster microinsurance schemes.

Moreover, governments can also move towards more equitable and inclusive labour markets. Since labour is often poor people's main or only asset, equitable access to decent work is one of the most important aspects of risk reduction. Furthermore, the speed and quality of economic growth needs to be optimized, while increasing employment elasticity and the share of formal work in total employment; both will facilitate the ability of governments to mobilize compulsory funding for universal coverage (WHO, 2004). Lastly, the more the formal sector expands, the less alternative insurance mechanisms are needed, since formal sector workers are easier to provide with adequate formal social security coverage.

Besides taking direct action to create a healthier living environment for the poor, the government can also be involved in social marketing campaigns to build greater awareness and understanding among citizens of the significance of risk prevention and risk avoidance. Several microinsurance schemes, including BRAC and Grameen Kalyan in Bangladesh, participate in the government's immunization programme campaign directed at children. Vaccines are provided free of charge by the health authorities and small contributions are made to cover the cost of promoting the campaign. Such participation may strengthen the schemes' own prevention programmes and enhance their public image. However, evidence from public health campaigns suggests that they have not always been effective in changing people's behaviour.

Social marketing can also extend to promoting risk-management strategies and trying to create an insurance culture. Indeed, the lack of an insurance culture is regularly identified as a major obstacle to the expansion of microinsurance, and one that the government could address with limited resources. The government could either undertake this itself or encourage the insurance industry to assume responsibility.

Sensitization campaigns on the characteristics and specific advantages of microinsurance might explain how to participate in and set up schemes and describe the rights and obligations of policyholders, as well as the costs of cover, which are often overestimated, and the costs of not having social insurance, which are usually underestimated (GTZ, 2005). Social marketing might help reduce consumer misconception and unrealistic expectations, which can represent a major obstacle and lead to mutual lack of understanding (Huber et al., 2003).

In Guatemala, for example, one of the key themes of the Banking Superintendency (which includes the Insurance Delegate) is to promote best practice in risk management, for financial institutions and clients alike. The head of the insurance section is encouraging insurers to take the lead – rather than

the Superintendency – in the introduction of best practice for risk management through a focus on: (a) corporate practices, (b) clients' code of ethics and (c) consumer protection (Herrera and Miranda, 2004).

2.3 Research, information and supply of healthcare facilities

Another aspect of the enabling environment is that certain services need to be in place for the insurance industry to function properly, notably research findings, relevant information and a supply of adequate healthcare facilities.

Dealing with risks involves recognizing their sources and characteristics, e.g. whether they affect individuals in an unrelated or simultaneous manner. The most appropriate combination of risk-management strategies and arrangements in any given situation will depend on the type of risk and on the feasibility of the available instruments (Dixon et al., 2002). Sound information and statistical data may help in arguing the case for universal coverage and hence the need for microinsurance as one element in a larger social protection framework.

Moreover, the more information microinsurers have to determine appropriate prices and product features, the lower the premiums should be for poor policyholders. Statistical services for the insurance industry need resources and capacity. Such services, which could be supported by the state, would provide information that helps insurers in setting premiums and benefit packages. In health insurance, for example, this might include information on disease prevalence, the relative quality of facilities, and the recommended cost of different interventions. It can also facilitate the sharing of experiences and lessons learned among institutions and individuals involved in microinsurance and its promotion.

Another element is the supply of adequate healthcare facilities. In fact, the accessibility of existing health facilities and the quality of care they provide

Box 97

Health service providers and mutual health organizations (MHOs) in Mali

The most important partners of UTM (Union Technique de la Mutualité Malienne) are health service providers, which have a symbiotic relationship with the MHOs. Indeed, most MHOs are structured around a health centre (*aire de santé*) that delivers services to the people living within a certain geographical area. The healthcare providers benefit from the presence of MHOs as they ensure that the local population has the financial means to access services and many have often played a central role in the creation of new MHOs.

Source: Adapted from Fischer et al., 2006a.

represent key determining factors for any health insurance scheme's prospects of success (*see Box 97*). Therefore, governments can support and promote the development of microinsurance by improving the availability, accessibility and quality of health services for all citizens in its primary healthcare centres and public hospitals (ILO, 2002c).

Healthcare providers are an essential element for the success of a health microinsurance scheme. Where the schemes can work in partnership with public providers – like UTM and UMSGF (Guinea) – they are better able to control costs because the public health providers often charge fixed fees. Public healthcare providers tend to be less expensive since their operations are partly or wholly subsidized by the state. If microinsurance schemes want to minimize claims costs, they need to find ways to work with the public health schemes better. A government supportive of microinsurance could certainly help in this regard. For example, in the case of Karuna Trust, a coordination committee has been formed to improve the quality of healthcare services, including representatives of the Ministry of Health and Family Welfare, as well as representatives of Karuna Trust and the insurance company. The coordination committee meets regularly to monitor the implementation of the insurance scheme.

2.4

Corruption and fraud

Corruption, if widespread, can present a significant barrier to the development of microinsurance and seriously hamper a scheme's chances of success. For instance, healthcare providers are supposed to depend upon formal payments and not demand under-the-table payments for admission to public facilities. Equally important in this context is fraud perpetrated by insureds who, for example, might claim fictitious healthcare costs, or by administrators who divert monies collected by the insurer (Weber, 2002). Governments can play an important role in fighting corruption and ensuring the credible and transparent functioning of healthcare delivery and financial settlement mechanisms (Ranson and Bennett, 2002).

Interestingly, the promotion of microinsurance schemes can also help to reduce fraud to some extent, at least in healthcare centres. For example, at UMSGF in Guinea, preliminary surveys conducted in the region showed that the average declared cost of hospitalization (medical or surgical) was GNF 80,000 (US\$33) per stay, which was much higher than the official prices charged by health providers (which on average are GNF 20,000 (US\$8.20)). Consequently, the microinsurance scheme chose to implement a third-party payment arrangement so that members did not have to pay for the treatment up front. By removing the financial exchanges between health staff and patients, it also reduces illegal practices such as over-charging.

3 Strengthening institutions

Besides creating an environment in which microinsurance providers and products might flourish, governments can also target interventions at an institution level to strengthen microinsurance providers and facilitate partnerships.

3.1 Networks and apex structures

For microinsurance to be successful, local, occupation-based units need to be linked to larger network structures to enhance representational functions and widen their risk pool. The experiences in Mali (UTM), Senegal (CRMST) and Guinea (UMSGF) demonstrate how a federated structure strengthens the system (*see Chapter 4.3*). This critical linkage also provides a support structure for more professional operations, through internal control and performance-monitoring, advisory services, training, data banks, research facilities, sharing of lessons learned and relevant data, and liaising with external stakeholders. Networks also play a key role in starting up new schemes, and therefore expanding the availability of microinsurance and increasing the economies of scale.

Accordingly, governments should, whenever appropriate, encourage the creation of microinsurance associations or support existing ones. The financing of these support structures poses a major challenge, since many of them do not collect enough from their members to fully cover their costs. This may be an area where government subsidies could also be effective, as discussed in the following section. In addition, the government can also facilitate links to appropriate support organizations, including government agencies and local administrations, to foster mutually beneficial partnerships (*see Box 98*).

Box 98

Stewardship in Guinea-Bissau

In Guinea-Bissau, the Ministry of Public Health has outlined specific responsibilities for village leaders regarding community-level health prepayment schemes. The policy framework allows a high degree of autonomy in scheme management, but holds the village accountable for various functions. For example, villages are free to decide the prepayment scheme's parameters (per capita, per adult or per household) and the timing of payments. Similarly, larger villages may create special health subcommittees to oversee the operations of village health centres.

The guidelines also specify the responsibility of villages. These include constructing health centres, for which the Ministry of Public Health provides some construction material, and ensuring that there are always adequate drug supplies. In this fashion, the partnership between the Ministry of Public Health and villages benefits from both the stewardship capabilities of the government in the form of guidelines and monitoring and from the local knowledge within villages.

Source: Adapted from Ranson and Bennett, 2002.

3.2 Link to donors and international funds

As described in Chapter 5.1, international assistance can help to promote microinsurance schemes, be it through direct cash transfers or through technical assistance. Yet microinsurance providers may not have the capacity, know-how and professional networks to establish contacts and negotiate terms of assistance with potential donors and/or international funds such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the International Finance Facility (IFF), or under the innovative concept of a Global Social Trust (GST).¹ They rely on the government to play an intermediary role between external assistance and – ultimately – the target population (*see Box 99*). In this context, the government's interest in microinsurance determines the volume and scope of external donor assistance, for example by setting priorities in bilateral and multilateral negotiations.

Box 99

Facilitating links to UNDP in India

The Indian Ministry of Health decided to set up pilot schemes in West Bengal and Karnataka to test community health financing options and to learn from the experiences. It agreed to work in partnership with established and successful NGOs; Karuna Trust was approached in 2001 on the recommendation of the Government of Karnataka. The scheme was designed to focus only on the public health centres. Karuna Trust's microinsurance operations started in 2002, with the NGO serving as the distribution agent for the government-owned National Insurance Company.

The main benefit of the insurance product is a per-diem payment to the insured when they are in hospital. Public facilities offer free treatment for those living under the poverty line or charge very modest fees for surgery

¹ This concept is part of a wider campaign of the ILO to encourage countries to extend social security, and links developed and developing countries to enhance and extend social protection schemes in the latter (*see Box 14 in Chapter 1.3*).

and hospitalization, outpatient services and (partly) drugs. The basic idea of Karuna Trust's insurance scheme is for the poor to use these free services instead of having to purchase them from other sources. The benefit package is intended to compensate for the weaknesses in the public healthcare infrastructure by compensating for wage loss. If the policyholder is hospitalized for more than 24 hours in a public health facility, Rs. 50 (US\$1.10) is paid per day as compensation for wage loss, for a maximum of 30 days per year. All hospitalized persons are eligible.

To overcome the market's lack of knowledge of insurance, UNDP agreed to cover the premium costs for the first two years. A fully-subsidized premium might have made sale of the product easy, but in retrospect, it might not have been the best policy. It is difficult to persuade clients to pay for insurance that has been free of charge in the previous two years. Karuna Trust is now striving to overcome this problem.

Source: Adapted from Radermacher et al., 2005a.

3.3 Facilitating linkages with commercial insurers

In some countries, important microinsurance providers might include employers' and workers' organizations, service providers, professional associations, civil society groups and cooperatives. In particular, microfinance institutions that already have financial transactions with low-income households can play a key role in also providing insurance. All of these organizations may extend insurance to the poor, either on their own, in partnership with formal insurance companies, or within the framework of public-private partnerships.

As discussed in Chapter 4.2, the partner-agent model is a viable way to expand microinsurance. It links a commercial insurance company with an appropriate distribution channel to reach the poor, to the advantage of the insurer, the agent and the client. Given the mutually beneficial results of such a model, governments could help facilitate links between insurers and potential delivery agents.

Besides facilitating links, governments need to develop a legal framework conducive to such collaboration. For example, the Indian Insurance Regulatory and Development Authority (IRDA) has relaxed the licensing standards for microinsurance agents (*see Chapter 5.2*). It is also important to recognize that such relationships are not always mutually beneficial, especially when the delivery agents do not have a strong grasp of insurance concepts and therefore do not negotiate good deals for their clients. Consequently, governments also must ensure that consumers' rights are respected and quality standards are met.

4 Providing financial assistance

Where microinsurance can be delivered purely on a market basis, financial support from the government is not needed. However, there are numerous situations in which purely market-driven microinsurance is not possible. For example, it can take several years for new insurance operations to be sustainable, except for the partner-agent model, which utilizes existing infrastructure. Market-based microinsurance is unlikely ever to reach the poorest and most destitute members of society, and therefore financial assistance might be required to extend the outreach of microinsurance schemes (i.e. serve poorer people). Subsidies may also be required for research and development, such as creating new products, enhancing benefits or experimenting with technology. Furthermore, apex structures may require financial assistance, at least until there are sufficient members to achieve economies of scale. Given the potential need for financial assistance, governments have to decide if they are going to make such investments, and if so, how they can be designed most effectively (*see Boxes 99 and 100*).

4.1 Targeted transfer payments

To help deepen the penetration of microinsurance schemes, governments could include the provision of transfer payments to the poorest citizens unable to pay (in full or in part) for insurance (Dror and Preker, 2002). Targeted transfers to the poor have an important welfare impact. In this context, a political decision needs to be taken relating to the subsidy recipients: what are the selection criteria, and how can reliable statistical data be obtained on the poor and the poorest, their incomes and where they live?

In reality, many microinsurance operations depend on continuing access to some form of external subsidy. For example, VimoSEWA, which has been involved in microinsurance in India for more than a decade, experienced a loss ratio of 176 per cent in 2004 and a (projected) loss ratio of 154 per cent in 2005 based on the high claims for its health insurance benefits (the other product lines now provide a positive contribution).

As discussed in Chapter 5.1, subsidizing premiums may not be the most appropriate form of public intervention. Indeed, subsidizing health insurance schemes in places with restricted supply may lead healthcare providers to be less inclined to provide services to non-members, who are perceived as more likely to default on payment (Bennett, 2004).

Where the fiscal impact of subsidizing too many individuals would be unsustainable, the limited resources need to be targeted at the most vulnerable. In addition, most systems require some form of co-payment. The inten-

tion is to limit the cost to the public budget, but also to counteract opportunistic consumer behaviour (moral hazard). Another purpose of public transfer payments may be to close the recovery gap, which occurs when there is a systematic excess of expenditure on benefits over the income of a microinsurance unit.

Overall, based on a country's needs, administrative capacity, banking system and political priorities, transfer payments can be:

- given directly to individuals to acquire insurance;
- provided to support new schemes (*see Box 100*);
- given to the social or community-financed microinsurance schemes (either regularly or during financial crises, both of which are likely to improve their financial viability);
- paid into a financial pool (through mechanisms including reinsurance);
- given to providers to cover investments or uninsurable services or
- provided in the form of tied transfers (direct and indirect), i.e. as subsidies that encourage the use of preventive care, primary care and essential pharmaceuticals.

In reality, a balanced mixture of these options has to be found. Considering the many market imperfections, it could be argued that subsidies would be used more efficiently if channelled through government providers or tied to certain goods or activities. At present, however, there is insufficient data to suggest that one type of subsidy is superior to others (Ranson and Bennett, 2002).

In providing subsidies for microinsurance, governments need to understand the effects on non-members as well as on members, and analyse whether overall governmental objectives are being optimally met given the chosen combinations. In general, it should be noted that subsidies do not guarantee social fairness or improved access for the poor – how the money for subsidies is raised and how it is spent are both important factors (Busse, 2002).

Box 100

Subsidizing Yeshasvini Trust

Yeshasvini Trust is designed as a self-funded insurance scheme, financed mainly through members' contributions, although it relied on additional subsidies to start. In the first two years of operation, the clients paid Rs. 60 (US\$1.36) per person as a premium. For persons below the poverty line, the Government of Karnataka complemented the premium collected with an additional Rs. 30 per person (US\$0.68). Altogether, the state government provided Rs. 45 million (US\$1,022,727) in the first year and Rs. 35 million

(US\$795,454) in the second year. However, the state's assistance goes beyond mere financial support.

Since Indian cooperatives are somewhat dependent on the government, the Department of Cooperatives can influence their involvement. The decision to allow members to simply deduct the insurance premium from their business income generated with the cooperative society was a major incentive for new members to join. The cooperatives are Yeshasvini's key to large numbers of insureds, covering 1.6 million members in the first year, and growing to 2.2 million in the second year. However, as the subsidies were phased out, the premium had to be increased to Rs. 120 (US\$2.73), which significantly undermined renewals. In the third year, only 1.45 million members subscribed, illustrating the disadvantage of subsidizing the premiums.

Source: Adapted from Radermacher et al., 2005b.

4.2 Reinsurance

Reinsurance is another way in which public intervention could contribute to the viability of microinsurance schemes. As microinsurance is often used by a targeted population living in close proximity, the risk pool is not well diversified by location or occupation. Social reinsurance techniques could be used to improve the viability of small risk pools typical of informal microinsurance schemes (Dror and Preker, 2002).

However, just as the poor have no access to insurance, microinsurance providers typically have no access to reinsurance (*see Chapter 5.4*). If the market-based reinsurance options of microinsurance schemes are insufficient, and in the absence of feasible reciprocal arrangements, the government may encourage and support the development of reinsurance mechanisms by either:

- reinsuring microinsurance schemes directly against certain covariate risks (the government may both establish a fund and make financial contributions to the pooled resources, i.e. a combination of reinsurance and subsidy) or
- subsidizing the premium microinsurers would have to pay for reinsurance.

Some observers argue that this approach is not sustainable, may create negative incentives and could perpetuate poor microinsurance designs (Newbrander and Brenzel, 2002). Given the limited practical experience in this area, it is not clear what financial resources, managerial capacity or institutional features a government would need to reinsure successfully. An alternative approach would be to facilitate links between microinsurers and government-sponsored reinsurers (*see Box 101*).

Box 101

Africa Re

The African Reinsurance Corporation (Africa Re) was established in 1976 by the 36 member states of the Organization of African Unity with the aim of reducing the outflow of foreign exchange from the continent by retaining a substantial proportion of the reinsurance premiums generated. Its members are national governments, the private sector and the African Development Bank.

The purpose of Africa Re is to foster the development of the insurance and reinsurance industry in Africa, to promote the growth of the national, regional and sub-regional underwriting and retention capacities, and to support African economic development. To achieve its purpose, it:

- transacts reinsurance business through treaty and facultative cessions;
- creates and administers pools;
- assists in the establishment of national and regional insurance and reinsurance institutions;
- invests its funds in African countries in a manner that promotes the continent's development;
- provides technical assistance to African countries and promotes contacts and business cooperation among insurance and reinsurance institutions.

Africa Re is exempted from all taxation. It also can transfer its funds freely and has the freedom to open convertible bank accounts. These privileges have enabled it to grow without major regulatory hindrance. Africa Re's first experience in microinsurance was with the Kenyan MHO Mediplus and it now reinsures Microcare in Uganda.

Source: Adapted from Africa Re, 2003.

5 Concluding remarks

Microinsurance is not designed to become the main pillar of a country's social protection system, but it provides a complementary strategy that might be applied within a larger framework. As a first step, the government needs to facilitate a participatory process with key stakeholders to weigh the pros and cons of microinsurance and assess whether this approach would contribute to the country's overall social policy objectives. If it is decided to include it in a broader social protection framework, the government may facilitate the formulation of an explicit policy on microinsurance, consistent

with all other relevant policies, which will be helpful in creating an environment conducive to building confidence in microinsurers.

Subsequently, governments can assist in the creation, replication and development of microinsurance through a variety of instruments. In this context, the government's first responsibility is to create a favourable climate for its development, beginning with regulatory adaptations that are directly and indirectly related to microinsurance. The creation of an enabling environment also involves the promotion of loss-prevention campaigns, cultivating an insurance culture, and the reduction or elimination of corruption and fraud. Other important instruments include research on microinsurance, as well as the dissemination of research findings and lessons learned.

The government's options for the active promotion of microinsurance include institutional support and financial assistance. Institutional support mainly involves the promotion of microinsurance networks and sound apex structures, linking microinsurance schemes to donors and international funds, and facilitating links between potential delivery agents and commercial insurers.

Financial support appears to be critical if governments wish to extend coverage to the poorest population groups. This could be provided through targeted transfer payments to ensure a high level of participation by the poorest and most vulnerable people, to improve the financial viability of microinsurance schemes, to cover certain socially important investments by providers or uninsurable services, or to encourage the use of preventive care, primary care and essential pharmaceuticals. Financial assistance also includes the government's role in reinsuring microinsurance providers against covariant risks.

The optimal combination of instruments will vary from one country to another, and within one country as it moves through different stages of development towards universal coverage.

The role of insurers and reinsurers in supporting insurance for the poor

David M. Dror and Thomas Wiechers

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In his address to the Microinsurance Conference sponsored by the Munich Re Foundation in October 2005, Hans-Jürgen Schinzler¹ offered his perspective on why commercial insurers and reinsurers were infrequent players in the low-income market: “Premium income is low, administrative costs are relatively high, and infrastructure for insurance is lacking; that’s why commercial insurers have not taken more interest in this market.”

This candid statement suggests that if premium income were high and administrative costs were relatively low, and the infrastructure for insurance were improved, commercial insurers and reinsurers would take more interest in this market. This raises two issues: first, what is the value proposition of commercial insurers and reinsurers for microinsurance schemes and the market of low-income clients? Secondly, as improvements on all three counts are more likely to evolve over time than to occur through a “big bang”, what part(s) of this value proposition can insurers and reinsurers deliver during this evolutionary process? This chapter proposes a few answers to these questions.

The answers might differ according to the business model. This chapter focuses mainly on the role of insurers and reinsurers in supporting community-based insurance schemes that operate the mutual model, namely communities of individuals that bear the insurance risk and operate the scheme. The provision of much-needed reinsurance, training and technical support to these microinsurers is a key challenge for the development of microinsurance. This chapter refrains from dealing with microinsurance arrangements in which NGOs distribute insurance products but do not underwrite the risk (the partner-agent model), because these grassroots organizations are already associated with a specific commercial insurer. That insurer may or may not cede risks to reinsurance depending on ceding decisions that are not specific

¹ Hans-Jürgen Schinzler is the Chairman of the Supervisory Board of Munich Re and Chairman of the Board of Trustees of the Munich Re Foundation.

to the agent. This chapter is inspired by the attitude that commercial insurers and reinsurers can capture viable business opportunities from a wider penetration of insurance in low-income settings, and that these opportunities justify the investment in microinsurance schemes because of their potential to serve as change agents in low-income communities.

1 The value proposition of reinsurance

The value proposition of reinsurance is its enhancement of primary insurers' ability to conduct their business by reducing the long-term cost of the underwritten risk. Reinsurance deals routinely with four main financial exposures: 1) capacity, 2) surplus relief, 3) catastrophes and 4) stabilization. Additionally, reinsurers provide ancillary services that complement the knowledge base of insurers. All of these services are relevant for microinsurers.

Every insurer (and microinsurers are no exception) can achieve the aim of reducing the cost of underwritten risks better when the number of clients increases. Taking on more insureds increases the predictability of business results, but it also means that for the overall quantum of claims and for catastrophic events the insurer becomes more exposed to the possibility – if only temporarily – that insurance losses could exceed premium income. Hence, insurers wishing to sell more insurance contracts than their own financial limits allow need to extend their financial **capacity**. Increasing capacity expands insurers' ability to underwrite a single large loss exposure (*large line capacity*) or many contracts in one line of business (*premium capacity*). Incidentally, the additional capacity needed is not proportional, but is less as the insurer grows.

Premium capacity enhancement is probably more relevant in the context of microinsurers (*see Box 102*). This can be achieved either through proportional reinsurance methods (e.g. “quota share” or “surplus”) or through non-proportional reinsurance (e.g. applying a method called “risk of excess loss”). Since reinsurance is an expense, the microinsurer will wish to compare the alternatives for capital; those that can access cheaper capital will prefer to do so rather than opt for reinsurance, but in the absence of alternatives, reinsurance is useful.

Insurers collect premiums in advance, but know what portion of the premium they retain as earnings only retrospectively. Hence, at certain times, insurers hold premium income that they have not yet earned. Insurance regulations oblige insurers to keep surpluses reflecting premiums collected but not yet earned, which should equal the present value of future claims. However, microinsurers have to reserve all unearned premiums and at the same time bear all costs in the current year. This has a negative effect on the

Box 102

What do microinsurers get out of reinsurance?

Reinsurance gives microinsurers a discretionary budget and protection against insolvency.

Protection against insolvency is the fundamental advantage. The reinsurance contract guarantees that the reinsurer pays all costs above the reinsurance threshold, and thus the microinsurer's risk of failure is limited to below-threshold costs. The cost of the reinsurance premium must compare favourably with the safety margin that the microinsurer must maintain. The safety margin is proportional to the variance of the microinsurer's benefits. Studies have shown that reinsurance presents a clear advantage for microinsurers, particularly as their specific benefit package evolves in terms of diverse products and higher maxima (Dror et al., 2005a).²

Reinsurance can also relieve microinsurers of the need to maintain contingency reserves to cover higher-than-expected costs in bad years. These reserves are normally accumulated in good years. Obviously, reinsurance does not affect the probability of good years, but when it relieves microinsurers of the need to keep reserves, they can use surpluses accumulated in good years as **discretionary budgets** without taking any additional risk of insolvency.

The practical implications are that microinsurers measure the benefit they obtain according to two yardsticks: first, the larger the premium they need to pay to avoid failure and secure full solvency, the smaller the benefit; second, the larger the amount of discretionary budget they can obtain, the larger the benefit.

² In Chapter 3.6, the opinion is presented that ceding risks to reinsurance is as much a management decision as the result of a set of calculations of the primary insurer's exposure. The authors of that chapter hold the view that, in certain circumstances, the choice may be subject to the exercise of judgment by management. This is particularly valid when the underlying terms of insurance are less than optimal due to extreme limitations on benefits. For example, when the expected incidence of an event is high, its predictability will also be high, and consequently its variance will be low. Variance also decreases when the benefit package includes few uniform benefit types and low maximum benefit amounts, because claims then become more predictable. There is less need for reinsurance in such cases, because the incidence of claims and amounts for claims submitted is reduced to a degree that renders fluctuations low and the financial protection of insurance less relevant.

Experience with microinsurance suggests that for many life products, claim amounts are constant due to the uniform coverage; therefore, the random variable "aggregate claim variance" would tend toward zero. For credit life, there is some variance in the outstanding loan amounts, so there is a contribution to aggregate claims variance. For health, if there is a low benefit maximum (as is frequent at present in health microinsurance schemes), contribution to aggregate claims variance would be small; in fact, the higher the number of clients reaching the maximum, the lower the contribution to variance.

Finally, it should be borne in mind that the reinsurance programme comes at a cost; thus, over-insurance can be as detrimental to the overall cost-benefit situation of the organization as under-insurance. Catastrophe reinsurance is one form of reinsurance that should not cost much and would be useful in most situations. The other functions of reinsurance are usually not used by microinsurance schemes.

microinsurer's results and may cause liquidity problems. Buying quota-share reinsurance would enable the microinsurer to reduce the unearned premium reserve; additionally, the microinsurer would receive a commission from the reinsurer, which would contribute to covering the costs and improving results. This is amplified when microinsurers experience rapid growth. Fledgling insurers may also have difficulty managing the surplus account, particularly early in financial periods, and when the client-base increases rapidly. Some insurers find it easier to meet this surplus requirement by buying **surplus relief**, also known as financing, from a reinsurer.

Insurers accept the risks of their insureds on the basis of statistical assumptions about the probability and variance of risk occurrence. However, every insurer also knows that there is a small possibility that the company's survival might be endangered if worst-case scenarios occur. **Catastrophe protection** is the preventive measure taken by insurers to spread exposure to fundamental risks that can endanger the company's survival. The prevalent reinsurance methods that offer catastrophe protection are catastrophe per occurrence excess-of-loss and aggregate (stop) excess-of-loss, both non-proportional methods of reinsurance. There seems to be broad consensus that catastrophe reinsurance is indispensable for microinsurers. Low volumes should not be a limiting factor for the provision of this reinsurance. In fact, in a historical perspective, one of the main tasks of professional reinsurers has always been to help small insurance companies to remove their existential risk first. Microinsurance companies should be able to access the same service.

Finally, insurers wishing to operate within a predictable and stable environment may wish to keep loss ratios within defined tolerance levels and/or ensure steady profits. This **stabilization** (or stable loss experience) can be achieved through reinsurance (but, of course, reinsurance is not a subsidy, and microinsurers will have to pay in good years for what they receive as compensation in bad ones). Most reinsurance methods can be used for this purpose.

In addition to the four main financial functions described above, reinsurers often sell expertise in insurance mathematics and statistical information on the market. Reinsurers can offer **underwriting expertise** because their client-base includes more than one insurer in the same or similar markets. This superior access to information gives reinsurers a relative advantage in preparing statistical estimates of risks and costs. In addition, reinsurers specialize in the expertise that is required for the insurer to decide which risks to cede to reinsurance and which risks to retain. The caveat to this general description is that, at present, reinsurers do not offer much expertise to microinsurers.

Reinsurers are also instrumental in cases where the regulations require insurers to reinsure certain risks. Reinsurance that is prescribed by regulations rather than by autonomous cession decisions of the insurer is essential for insurers to meet regulatory requirements. This is why it is often called **compliance assistance**.

Finally, insurers who decide to withdraw from an entire class, line, territory or book of business may cede the entire portfolio to reinsurance, although in reality it is more likely to see a competing insurer take the market share over. This enables insurers to continue to service clients without breach of contract, while no longer assuming any financial exposure linked to this portfolio. This is called **portfolio insurance**.

The focus of this chapter is on the contribution of insurers and reinsurers to microinsurers. The chapter first considers the evidence from the case studies regarding relationships between insurers and reinsurers with microinsurance schemes, and then describes options to expand the range of opportunities for microinsurers to benefit from the value proposition of reinsurers.

2 Involvement of commercial insurers and reinsurers in microinsurance

The case studies listed in Appendix 1 provide several examples of cooperation between commercial (re)insurance companies and microinsurance organizations, as described below.

1. The relationship between Spandana, an Indian microfinance institution, and the Life Insurance Corporation of India (LIC) was short-lived because LIC's products and processes did not match the priorities of the target population. Instead, Spandana chose to design its own life insurance product based on the mortality data it had obtained from LIC. Interestingly, Spandana found that its own product generated excessive surplus, using the same mortality rates and the same premium as LIC had. Spandana, therefore, added more benefits without increasing the premium. Providing in-house insurance enabled significant improvements in claims settlement as well.

2. Spandana could not obtain reinsurance because it is not a licensed insurance institution. It chose to minimize the threat of covariant risk in two ways: excluding risks that could cause extremely high claims (e.g. deaths and damage caused by epidemics or natural disasters) and limiting benefits to a relatively low level. These measures reduced the attractiveness of the product and its usefulness for the insured; this loss of usefulness could have been avoided by reinsurance.

3. VimoSEWA (India) has an agreement with two commercial insurers, Aviva and ICICI Lombard, under which it maintains responsibility for distribution, premium collection, record-keeping and claims payment. The commercial insurers set the premium and underwrite the risks. Responsibility for product design is shared through an informal consultative process between the insurers and VimoSEWA. This division of labour leaves VimoSEWA with certain functions that are not typically carried out by insurance agents. Additionally, VimoSEWA's responsibility for keeping records and settling claims gives it access to more information than the typical agent would have. With some underwriting assistance, VimoSEWA could exercise more control over the pricing of the insurance products, with a view to verifying that the profit margins of the insurers are fair.

4. In 2001, Shepherd (India) entered a two-year partner-agent contract with insurance companies HDFC-Chubb and ICICI Prudential. Assuming that the low premium levels did not justify investment or involvement in this community, the insurance companies kept their contacts to a minimum. However, claims processing, which was run from the head offices of the companies, brought to light that the insurers had gained insufficient understanding of the conditions and requirements of the insured: the procedures were too slow and too complicated for the policyholders and thus complaints and dissatisfaction followed. To remedy this unsatisfactory situation, Shepherd moved its commercial partnership to LIC. Representatives of LIC visited microinsurance policyholders repeatedly and discussed insurance products and processes. This greatly enhanced LIC's knowledge of the market and created a higher level of acceptance and understanding of insurance among the community members. It also led to an agreement under which the role of Shepherd was enlarged to pay out claims in advance and get reimbursement from LIC. For this purpose, LIC provides Shepherd with a management information system that enables it to collect and analyse data more efficiently and reliably.

5. For health insurance, Shepherd has a second insurance partner, United India Insurance Company (UIIC). The relationship with UIIC is structured using a similar approach: Shepherd ensured that UIIC representatives met prospective clients before entering the partnership. During the meetings, UIIC gathered information on healthcare expenditure to be covered under the policy, the premiums members were willing to pay and the benefits that clients would expect or prefer to be included in the package. UIIC designed the UniMicro policy based on this information. However, certain decisions on exclusions from the policy based on the age of the insured or membership

in Shepherd were entrusted to the microinsurance members, thus enhancing the relevance of the qualifying conditions and the community's ownership for the scheme. Additionally, UIIC and Shepherd established an "Insurance Review Committee", which is composed of representatives from UIIC, Shepherd and the insureds to monitor underwriting and claims processing practices, respond to complaints and solve problems.

6. ASA in India is another MFI that assumed an intermediary role between a commercial insurer and the clients. ASA moved its commercial relationship from UIIC to LIC in response to a supposedly better offer. However, it soon became clear that the move was not entirely without drawbacks. For instance, LIC did not cover death during childbirth, suicide or death caused by snakebite or drowning. LIC asserted that these exclusions were standard in the insurance industry, but this explanation did not satisfy ASA's clients who knew that these benefits had previously been covered. Additionally, it took LIC a long time to process claims and it paid them by crossed cheque, which was of no use to many policyholders who did not have a bank account. In general, the daily management of the partnership with LIC became cumbersome and very bureaucratic. Hence, the expectation that the move to LIC would give ASA members a better deal was not fulfilled, due in part to insufficient interaction between the insurer and the community and possibly also to inflexibility in handling clients' dissatisfaction.

7. In 2002, the Indian Insurance Regulatory and Development Authority (IRDA) issued regulations requiring all insurance companies to transact a certain percentage of their business with poor and rural clients. These regulations define microinsurance as traits of the products, rather than recognizing the unique role of non-profit organizations such as ASA in the business process. Unfortunately, the regulations limit the role of these organizations to serving as agents of commercial insurers. Using its experience in dealing with insurance companies, and as it could offer a large client-base, ASA solicited bids from insurance companies willing to enter a partnership. The main criterion ASA applied when reviewing the bids was that the companies should agree to pay benefits directly to ASA and allow it to verify claims. Eventually, ASA chose to partner with three insurance companies (AMP-Sanmar, Bajaj-Allianz and Max New York) on equal terms and with identical products. ASA's relationship with the insurers was driven in part by the fact that they could purchase reinsurance, a condition ASA considered essential, but which is available in India only to commercial insurance companies.

8. In 1997, AIG Uganda entered the low-income market with purely commercial intentions to establish profitable operations. Today, AIG Uganda provides accidental death and disability coverage to more than 1.6 million persons in East Africa through 26 MFIs. AIG Uganda operated without competitors in the market and its success in market penetration has been due in part also to specialized AIG staff agents who are actively involved in information dissemination. These agents receive commissions from AIG Uganda based on the volume of business. Thus, the agents have an interest in generating more business, and as they are responsible for certain operational aspects, they have an interest in efficiency as well. The agents provide an initial briefing to the MFI loan officers appointed to sell the insurance product to the MFI's clients. However, the loan officers generally have only limited knowledge and understanding of the product and do not need to meet any formal training requirements. The training they receive focuses on premium collection and an initial check of claim documents. Incidentally, AIG does not feel it requires reinsurance for this book of business.

9. The ALMAO scheme (Sri Lanka) has had reinsurance arrangements since 1992. First, it was reinsured with CUNA Mutual and then with the state-owned SLIC (privatized in 2003) on a quota share basis. After ALMAO's registration as a commercial company in 2002, it reinsured its risk with NTUC Income (Singapore). These treaties were concluded on a commercial basis.

10. The Yasiru scheme (Sri Lanka), registered in 2000 and collaborates with the Rabobank Group (Netherlands). The collaboration includes financial support through the Rabobank Foundation, the provision of technical know-how and the necessary hardware, software and training. Rabobank's reinsurance subsidiary, Interpolis N.V., has provided long-term reinsurance and technical assistance to Yasiru on concessionary terms. The cover offered by Interpolis is a 100 per cent quota share with a maximum of LKR 120,000 (US\$1,200) per risk. The reinsurance premium payable to Interpolis for the annual contract is 20 per cent of the gross premium income of Yasiru. In reality, under the concessionary arrangement, Yasiru retains 95 per cent of the reinsurance premium as a no-claims commission, so that in fact Yasiru pays only 1 per cent of gross premiums to Interpolis for reinsurance. Needless to say, this kind of concessionary reinsurance agreement is usually unavailable in the market. In 2005, the partners started to align the reinsurance agreement with more market-based terms, but the arrangement is still favourable for Yasiru.

11. The International Cooperative and Mutual Insurance Federation (ICMIF)³ used to provide assistance and reinsurance intermediation to its members around the world. The mission of ICMIF Reinsurance Services (RS) is to encourage reinsurance placements between members of ICMIF, to advise members on their reinsurance requirements and assist them in obtaining suitable cover with secure reinsurers within or outside ICMIF. One of the main methods by which ICMIF promotes co-operation and understanding in reinsurance is its Meeting of Reinsurance Officials (MORO), held every two years for reinsurance managers from members around the world. Such worldwide contacts give ICMIF's members an advantage in facilitating treaty placement. RS also provides reinsurance training, with two interactive business simulations: 1) *ReAction* models the reinsurance negotiation process between insurers and reinsurers, and claims success in team building, decision-making, communication and negotiation; and 2) *Morotania* combines a financial planning model with an interactive map to simulate challenges encountered by new, developing companies. Finally, ICMIF has produced a practical guide on establishing a suitable reinsurance programme.

12. ICMIF supported the Columna scheme (Guatemala) in obtaining reinsurance. The primary goal was to achieve long-term stability through reinsurance of the whole portfolio (including microinsurance), while keeping the reinsurance premiums to a minimum. Towards the end of each year, ICMIF and Columna prepare information and statistical data required to develop a reinsurance programme for the following year.

13. La Equidad Seguros (Colombia), which has reinsurance for its non-micro policies, wanted to obtain reinsurance for its microinsurance business. This was impossible because its total financial risk was lower than the deductible determined by the reinsurance provider. Therefore, La Equidad Seguros could not obtain reinsurance for policies below CoP 10 million (US\$4,100). Reinsurance is only provided for catastrophe cases exceeding CoP 150 million.

14. Delta Life (Bangladesh) experienced the same problem. As it is registered as a commercial insurance company, it has reinsurance treaties with SwissRe and Munich Re. However, these treaties do not include Delta's microinsurance businesses, because the deductible required is higher than the total amount of microinsurance risk. The high minimum premium reflects the low benefit amount and large number of insureds, and the concern of the reinsurer that many of the members will claim the maximum benefit.

³ Information on ICMIF has been obtained from its website: www.icmif.org

In conclusion, the case studies contain few references to symbiotic business relationships between microinsurers and commercial (re)insurers. Setting aside for a moment the “partner-agent” relationship (*which is covered in Chapter 4.2*), some of the examples can be defined as simplified versions of underwriting assistance. There are very few examples of reinsurance being used to prevent catastrophes. Interpolis Re, through its cooperation with its microinsurer partner, Yasiru, provides the only adaptation of the professional *modus operandi* to the specific prevailing conditions.

3**What part of this value proposition can insurers and reinsurers deliver?**

The few timid contacts between commercial players and microinsurers are based on a relatively rigid scope of products. There are a few examples where the negotiations between microinsurer and commercial insurer have led to a slightly better fit between what each partner expects from the relationship. However, most insurers and reinsurers do not have a clear strategy for servicing microinsurers, and therefore do not invest in acquiring knowledge of how to do it.

Microinsurers need large insurers only to the extent that those insurers enable them to a) sell a variety of products at low premiums and b) remain solvent. The first issue is directly linked to the fact that if the low-net-worth market is to pay a premium, insurers must ensure that they sell relevant insurance products at affordable prices. The second issue is linked to the legitimate concern of poor people that the companies they deal with will be there when the time comes for them to pay benefits. Large insurers seem to underestimate the long-term potential of this market segment and their need to work closely with a local partner if they are to conclude many small transactions. The evolution of business relationships between commercial reinsurance companies and microinsurers is largely contingent on delivering more variety at a lower per-contract cost.

What can insurers and reinsurers actually do now? They can make efforts to develop innovative ways of selling their services to the low-income market. The entry of insurers and reinsurers into business with microinsurers can be seen as an investment aimed at developing a business model for selling insurance in small portions so that these sales can aggregate to significant financial volume over time. This would be the equivalent of what was done in mobile phone business: the huge upfront investments in infrastructure are justified by large market penetration in the low-income segment.

Insurers and reinsurers can also provide services to microinsurers. For instance, when a microinsurance scheme wishes to increase its client base, it needs the financial capacity to underwrite many contracts in one line of busi-

ness (premium capacity). Reinsurance could easily satisfy this need with existing tools, although it may have to content itself with lower margins. The barrier is neither conceptual nor technical, but created by an unwillingness to underwrite the small volume of business. The anecdotes that some microinsurance schemes have not been able to obtain reinsurance because the total value of their portfolios was lower than the reinsurer's deductible are indicative of the gap between the two parties.

There is at least one example showing that such business relations are possible: the Interpolis Re model. This Dutch reinsurer has "adopted" a Sri Lankan microinsurance scheme and initially provided technical assistance to help the microinsurer to quantify and present its underwriting exposure. Interpolis also agreed to reinsure some of the risk, but with a higher than average "no claims commission" as a means of reducing the reinsurance premium to the bare minimum. It could be said that Interpolis absorbs excess risk of Yasiru, if it were to occur, with caps that are relatively low for the large reinsurer, but sufficiently large for the microinsurer.

Although details of how much this "hand-holding" costs are not available, it seems safe to assume that the amounts in question are probably quite modest. The arrangement can certainly not be considered as charity, as the main focus is on establishing the correct contractual basis for a business relationship between the microinsurance scheme and the reinsurer. This is why one can view the cost of the "hand-holding" as an investment in helping the micro scheme to professionalize its activity as an insurer. This creates a basis for the enlargement of commercial relationships (including a less concessionary reinsurance premium) when the revenue stream and the knowledge base of the micro scheme allow such a move. It is indeed noteworthy that, from inception, the relationship between Interpolis and Yasiru has been based on remunerated (but probably not for-profit) services.

Can this arrangement be scaled up to many more microinsurance units? Such a development is contingent on structuring the transition from privileged relationships to normal commercial interactions. Some hold the view that it is risky to start with subsidized reinsurance premiums because clients may resist premium increases later and because it deters insurers and reinsurers from entering such markets. Hence, it is necessary to consider ways in which the insurance and reinsurance industry can widely offer its value proposition to microinsurance schemes. Two courses of action seem particularly opportune:

1. Focus on building up the capacity of microinsurance schemes to assume a growing range of insurance activities, rather than limiting micro schemes to

the role of agents. This is particularly important in product types where the potential for conflict of interest between the agent (representing the insurance underwriter) and the microinsurance scheme (representing the clients) is acute.

2. Create a reinsurance facility that would service this market segment until it becomes sufficiently attractive for commercial insurers to manifest more interest, possibly with some public funding.

3.1 Capacity-building as a first step to professionalizing microinsurance operations

It is estimated that some 35 to 40 million persons are covered by microinsurance schemes worldwide, of which more than five million are covered by health microinsurance schemes in India alone (ILO/STEP, 2005a). There is a growing body of evidence that microinsurance schemes make a difference in improving the financial protection of clients through various types of insurance (e.g. Dercon, 2005; Morduch, 2006; Jütting, 2003; Dror/Soriano et al., 2005) and it is widely claimed that an information-intensive industry such as insurance cannot find sufficient technical knowledge at the community level (e.g. Brown et al., 2000; Schinzler, 2005). However, insurance must rely on comprehensive and solid data and sound underwriting expertise to be financially sustainable. Developing appropriate data collection processes and training the management is one of the key steps microinsurance providers must take to grow and attract commercial insurance and reinsurance. Existing training facilities are unable to rise to the challenge of training sufficient numbers of people to carry out technical roles. Consequently, the logical response is to create the institutional structure for more, better and faster training in skills directly related to the operations of microinsurance schemes.

The insurance industry, which is likely to benefit from such training, could make a tangible contribution to the development of training programmes, both in cash and in kind. Since public-private partnerships (PPP) are the preferred modus operandi of many development agencies, the insurance industry could enter into a PPP for capacity-building. The funds that the insurance industry would need to devote are very modest and can be complemented by funds from public sources. In addition, such modest contributions can facilitate the involvement of the industry in curriculum decisions and in supplying trainers.

The important role of commercial insurers and reinsurers today, and their strong interest in the development of the insurance sector notably at the micro level, implies carrying a share of the responsibility to create the missing “industrial infrastructure” for (micro)insurance, which they can assume by supporting institutionalization of training structures. It is noteworthy that for the time being, *there is not a single dedicated institute anywhere in the world that focuses on capacity-building for microinsurance operations*. There are a few initiatives to create resource centres for microinsurance;⁴ however, none has established a systematic approach to rolling out capacity-building at the grassroots level. Therefore, establishing a “Microinsurance Academy” that would focus on such capacity-building in domain knowledge is neither premature, nor a luxury, nor the sole responsibility of public authorities or the microinsurance schemes themselves.

Microinsurance requires different products and a different business model, which places some of the essential functions of the insurance value-chain with the community.⁵ Several examples from the case studies suggest the need to revise the classical training of insurance agents because the role of microinsurance schemes – even under the partner/agent model – goes beyond the classical agency role. For example, microinsurers sometimes operate front-office functions; communities sometimes play a pivotal role in securing broad-based affiliation and renewal, thus reducing the risks of adverse selection and free-riding, and communities can reduce moral hazard by using information freely available within the community to monitor utilization. Other roles for the community include involving the clients in benefit-package design and encouraging a higher willingness to pay through a better fit between products and client needs.

Creating one or more dedicated competence centres for microinsurance fits in with the wider development agenda that considers insurance and microinsurance not as ends in themselves but as vehicles for achieving higher socio-economic development goals. The Millennium Development Goals (MDGs) enjoy the widest recognition; they focus on poverty reduction and prioritize several main areas, of which health is one. It has been recognized that attaining the health-related MDGs requires new ideas to overcome systems constraints to delivering effective intervention.⁶ One of the key issues

⁴ For example, USAID has funded an initiative to create the MIRC (Micro Insurance Resource Centre) in India; a similar effort is being pursued by CARE India in collaboration with Bajaj Allianz. The Canadian Cooperative Association has also created a resource centre in the Philippines and in West Africa there are periodic meetings, organized by ILO-STEP, for mutual health insurance schemes to exchange information.

⁵ Several studies have concluded that the involvement of the community in the management of the microinsurance scheme is a critical factor for its success. For an overview of these studies see Jakab and Krishnan, 2004.

is health financing, where the divide between knowledge and production (the “know-do” gap) is still wide at all levels, but particularly large at the grass-roots level, hence the need to offer training so that community members can carry out the business processes and add value to outcomes. In this context, the contribution of commercial insurers and reinsurers to the MDGs could well be made tangible by their support for the establishment of an institutional training structure.

3.2 **Creating reinsurance capacity that is accessible to microinsurance units**

As stated earlier, reinsurance offers insurance companies many advantages, including stabilization of losses and surplus relief. Indeed, it is impossible to imagine today’s insurance industry foregoing its commercial relations with reinsurers. The situation of microinsurers is, however, completely different. Although these small schemes would have similar advantages if they could access reinsurance, the empirical experience suggests that they are usually unable to buy the full range of reinsurance services. The obstacles seem to be on the supply and regulatory side, rather than on the demand side.

At the Munich Re Foundation microinsurance conference, a proposal was tabled for reinsurers to create a “Joint Reinsurance Underwriting Association” or a syndicate to provide reinsurance to microinsurance schemes to reduce risk exposure while spreading the cost of developing the market. The objective is to enable microinsurers to buy reinsurance, while limiting the effort of each participating commercial reinsurer. This syndicate would have to overcome some definition problems, including a decision about which kinds of risks to accept, whether to operate worldwide or only within the boundaries of single countries, and so on. It would also have to deal with a microinsurance industry that is not always well managed. Most critically, such a syndicate would have to overcome a mental barrier that seems to impede cooperation between large reinsurers, who usually prefer to operate individually and have sufficient financial and technical capacity to do so. However, a syndicated facility by several reinsurers who see the merit of institutionalizing the access of microinsurers to reinsurance would fill part of the “missing industrial infrastructure”.

Another concept for the supply of reinsurance for micro schemes is the “social reinsurance” model, which emphasizes the need to reduce the exposure of microinsurance to claims fluctuations (*see Box 103*). The conceptual

⁶ *Mexico Statement on Health Research* issued by the Ministerial Summit on Health Research, Mexico, November 2004. The World Health Assembly adopted the Ministerial Statement as resolution WHA 58.34 in May 2005, following which WHO is now setting up a programme to close the “knowledge gap”.

analysis reported in the Social Re book (Dror and Preker, 2002) shows a way to remedy inherent vulnerabilities of microinsurance schemes operating on their own by establishing a generalized ceding limit (or threshold) identical to the long-term average cost of claims and passing on to the social reinsurer the risk of outlier claims. This enables microinsurers to remain financially viable and to calculate their premiums more accurately, while reducing their need to maintain capital for contingencies.

Box 103

A short summary of the social reinsurance model

The “social reinsurance” model offers a way to quantify microinsurers’ vulnerability and to examine the effectiveness of reinsurance as a remedy. The model deals only with considerations that can be predicted by the application of statistical laws. The focus is on the effect of fluctuations in microinsurers’ and reinsurer’s total benefit expenditure. Variance in total cost can stem from a small claim load or from a large variation in unit cost. A small claim load is likely to occur either when the group is very small or when the insured event is very rare.

The Social Re model is suited to deal with these circumstances. It can be applied when the standard deviation (SD) of each microinsurer’s total benefit cost is known. The reinsurer’s success is highly sensitive to the accuracy of this SD; a 20 per cent error in SD value can signify the difference between the reinsurer’s long-term solvency and bankruptcy.

The SD can be calculated only when the risk probability is known. In reality, the estimate of risk is often unreliable. Even when risk probability is known, the reinsurer is still affected by the size of the pool (or the number of reinsured microinsurers) and the heterogeneity of risk profiles. The larger the pool, the better the reinsurer can spread risk and reduce the variations in its business outcome and premiums. When the pool is small, the adverse effect of heterogeneous risk profiles requires a higher premium for stabilization.

When the reinsurance contract reduces the resources needed to secure at least the same level of solvency for a defined level of expenditure, it becomes an interesting option. This value proposition calls for a comparison between two quantities: the cost of a *safety margin* over and above the mean cost of benefits⁷ and *the reinsurance premium*. Reinsurance is advantageous when the reinsurance premium is cheaper than the safety margin (assuming that the reinsurance threshold is equal to the mean benefits).

⁷ Bearing in mind that 100 per cent survival (without reinsurance) can be guaranteed only when resources to cover the worst-case scenario are available at the beginning of the period, a microinsurer without reinsurance needs resources equal to its mean benefits, plus a safety margin proportional to the variance of its benefits.

The comparison between the two values is complicated because the microinsurer's expenses fluctuate, and thus the maximum capitalization needed is unknown. Since expenditure fluctuates, the microinsurer will need less than the maximum in some years and is challenged to operate with as little up-front capital retention as possible, without increasing the insolvency rate. When reinsurance is considered, the cost of the reinsurance premium plus the microinsurer's maximum liability (defined as the *reinsurance threshold*) ceases to be an estimate as it is defined in the reinsurance treaty. Hence, reinsurance also reduces the uncertainty for the microinsurer.

The reinsurance premium has to cover the reinsurer's solvency. The solvency rate of the reinsurer is assumed to be 95 per cent. The number of microinsurers in the pool and each pooled microinsurer's risk profile determine the reinsurer's solvency. A simplified example shows that each microinsurer needs 10 monetary units at the beginning of each period to ensure its solvency without reinsurance, but only half that amount of capital with reinsurance, when 30 identical microinsurers sign identical reinsurance contracts for one year.

Source: Adapted from Dror and Preker, 2002.

The social reinsurance model distinguishes itself from commercial models by the specific focus on the needs of microinsurers, including the option that microinsurance units can enjoy discretionary budgets for development of new benefits in years when claims are below the estimated long-term average. This feature is designed to motivate communities to reduce moral hazard and free-riding, as these phenomena counteract the interests of the insured.

Additionally, the link between social reinsurance and microinsurers includes a systematic access to technical assistance, including benefit-package design, claims processing, IT systems, etc. Since the success of social reinsurance depends on effective pooling of multiple micro schemes, it is necessary to develop and implement a standardized data-collection system and a data-transfer protocol.

Implementation of the social reinsurance concept can occur through multiple options of incorporation. It is essential that a way is developed for unincorporated microinsurance schemes to enter into reinsurance relationships so that they can offer viable protection to the low-income market. The mission of the social reinsurer is to serve as the conduit between microinsurers and the commercial (re)insurers.

4 Recommendations

4.1 Partnership-favouring considerations

Partnerships usually succeed when both sides consider the relationship to be beneficial. Many insurers and reinsurers in developed countries operate increasingly in stagnating markets, with much competition and shrinking profits. At the same time, new markets in emerging countries (e.g. China, India and South Africa) provide large untapped business opportunities. Some of these opportunities extend to high-net-worth individuals and companies, but the vast majority of the untapped client base is the low-income segment.

The experience of microcredit and mobile phones has demonstrated that financial services for low-income groups can operate profitably. The same applies to insurance; there are no inherent reasons why insurance for low-income persons should be unattractive commercially. However, success of insurance at “the bottom of the pyramid” requires the industry to adapt to the clientele, rather than expecting clients to adapt to the vendor. Adaptation in this context would refer mainly to front-office and back-office administrative practices, rather than to core business considerations such as diversification of risks over large risk pools and over long periods of time. The lower cost of computers, software and means of communication and better educational facilities make it feasible today to operate in low-income and rural population segments.

Insurers and reinsurers may find in microinsurers capable partners that simplify the process of entering the low-income market, and thus change the business paradigm of insurance. Businesses that depend on access to large numbers of clients for their success can no longer adopt a strategy of ignoring the majority of the world’s population.

Table 49 summarizes both internal factors (those arising from internal and organizational constraints) and external factors (demanded by external stakeholders and regulations) that favour partnerships for insurers and reinsurers.

At the other end of the partnership continuum, microinsurance schemes are also subject to internal and external pressures that favour partnerships with insurers and reinsurers. These factors do not apply uniformly everywhere, but they are given here (*Table 50*) to facilitate the understanding that partnerships are win-win business propositions in the long term.

Table 49

Partnership factors for an insurance or reinsurance company

<i>Internal factors</i>	<i>External factors</i>
– Corporate social responsibility	– Growing competition in traditional markets
– Risk diversification	– Shrinking margins in traditional markets
– Securing or growing revenue	– Regulatory requirements
– Push for new markets and innovative products	– Political and activist pressure
	– Liberalization of previously closed markets

Table 50

Partnership factors for a microinsurance institution

<i>Internal factors</i>	<i>External factors</i>
– Access to professional management practices	– Regulatory pressure to institutionalize or collaborate with a registered insurance
– Access to financial resources	– Documentation requirements by donors and/or government
– Implementation of standard insurance practices	
– Support in expanding products and coverage	
– Risk diversification or need to acquire reinsurance	

4.2

Establishing the partnership

Partnerships between microinsurance schemes and commercial insurers or reinsurers will occur when both sides agree to adjust and adapt to each other. The insurance products must be of interest to and affordable for the low-income market, and at the same time commercially viable. The viability of products is determined by an adequate fit between premiums and benefits, independently of business volumes. At the same time, also independently of business volumes, insurers and reinsurers must adapt their products to the needs and business model of microinsurers. At the present “embryonic stage”, business development entails on the one hand looking for solutions which enable microinsurers to operate profitably, and on the other hand recognizing that profitability may be compromised by start-up costs.

Reinsurance companies can help design products. Insurers can help commercialize products. However, neither insurers nor reinsurers are best placed to organize training activities, even though they can support this crucial activity financially and by allocating experts to training. It is tempting to suggest that the most promising approach to partnerships is to involve microinsurer, insurer and reinsurer from the beginning. However, the case studies do not offer much evidence to support that this suggestion has been followed very frequently. Instead, the more consistent conclusion from the experiences reported elsewhere in this book is that commercial insurers and reinsurers must acknowledge that microinsurers are not simply scaled-down ver-

sions of insurance agents. The different economic and social situation of low-income groups requires a critical review and adaptation of the processes applied and the products offered in the traditional insurance market. Secondly, microinsurers must do more than just expect others to adapt to their unique situation; they must take the lead in developing innovative approaches to tap what their clients want in product design, insurance practices and loading levels for administrative and capital costs. The evidence provided by the case studies suggests that the prevalent practices of commercial insurers or reinsurance providers are not in line with the needs of most microinsurers that underwrite risks.

The partnerships which enable microinsurers to obtain adequate domain knowledge and the necessary access to information, capital, hardware and software will, for the foreseeable future, constitute as much a means of collaboration to create the “industrial infrastructure” as pure commercial transactions involving the transfer of risk. It will take more than merely “win-win potential” to see the partnerships take hold on the ground.

5 Conclusion

Insurers and reinsurers have a vital role to play in the success of microinsurance schemes. They can make a concrete contribution to implementing business processes that reduce the long-term cost of underwriting risk for low-income persons. Partnerships inspired by this motive can be of interest for both sides, as the commercial partners are best placed to adapt tried-and-tested methods of reinsurance and other modes of risk transfer, and microinsurers can expand the financial capacity of their schemes and underwrite more and larger risks. Successful partnerships would bring more business for both sides.

Reinsurance offers microinsurers an untapped alternative way of enlarging their capacity to become the leading underwriters of sustainable insurance services for the poor. Microinsurance schemes are in most cases operated by people who do not have much expertise or experience in insurance. The leaders of microinsurance schemes are not necessarily aware of the services of reinsurance, including assistance in underwriting mathematics and statistics, or the use of tools for product design, administration systems or efficient marketing. In short, the leaders of microinsurance schemes are often unaware of the benefits of reinsurance.

The case studies have identified several noteworthy examples of cooperation. However, only very few are modelled as reinsurance partnerships. Thus, the challenge is to develop a reinsurance model for microinsurance that is commercially viable and replicable. The potential of the market, especially

in emerging economies with large uninsured low-income populations, justifies efforts to develop such a model.

Besides the cooperation between corporate and not-for-profit institutions, there is ample room for public-private partnerships, which could provide the platform for cooperation between public institutions or development agencies and industry-wide corporate bodies. However, whatever forms the partnerships take, the commercial partners should utilize their expertise in insurance mathematics, risk diversification and product design, and microinsurers must retain the lead in adapting the business to the reality of the clientele at community level.

Commercial insurers and reinsurers tend to underestimate the peculiarities of the microinsurance market. It is important to recall that microinsurance developed mainly because of the short supply of adequate products from commercial insurers. Therefore, cooperation could proceed when the commercial partners show more willingness to review their products and administrative processes. One must bear in mind that the business of microinsurance can be an extension of the market; even poor people will agree to pay for insurance if it responds to their perceived priorities.

Microinsurance schemes must learn to apply industry standards for risk management. The main issues revolve around a better link between premiums and the expected cost of benefits, and assimilating the mantra that “good bookkeeping is good business”. Commercial insurers must accept an active role in professionalizing microinsurance schemes. Both partners should share the effort to find ways of structuring a legal relationship, rather than hide behind the microinsurer’s lack of a corporate structure as an excuse to refrain from forming partnerships. The industry’s concerns about high administration costs and a lack of insurance infrastructure are matters that can be largely remedied by the insurance industry itself.

The insurance industry is reluctant to become involved with microinsurers due to the limited prospects of profit. There is no denying that the reward for risk, investment and effort should be profit, and the insurance industry should be entitled to make profits on services rendered. However, the degree of investment and the exposure of the industry to risk have so far been low. In today’s economy, profit-taking follows prior investment in creating the infrastructure. There is no reason why the insurance industry would be an exception – why should it look to earn profits but expect others to invest in building the industrial infrastructure that enables such profits to be made? By holding back on its involvement in microinsurance, the insurance and reinsurance industry weakens its claim to draw profits.

What investments should the industry make? This chapter has flagged two key possibilities. Firstly, it can support the development of a capacity-building institution, a “Microinsurance Academy”, to create insurance competence at the community level. Considering the need to have more and better information on the market, and the parallel need to keep the cost of gathering information low, it seems sensible to disseminate domain-knowledge and insurance skills among the people who are active in the microinsurance industry. This is as much in the interest of the commercial insurance industry as it is a matter for public concern.

Secondly, it can enable microinsurance schemes to access reinsurance. Lack of this option is due mainly to the unavailability of supply. As long as reinsurers are reticent to take the lead in offering reinsurance services to microinsurance schemes, it may be opportune to spread this risk over many reinsurers. The practical proposal is to create an institution established jointly by many reinsurers and, possibly, with the participation of public institutions, tasked with offering reinsurance and with developing and implementing a standardized data-transfer protocol that enables microinsurers to buy reinsurance. At present, no natural institutional leader has shown the will to take the lead in creating this facility. However, the initiative of CGAP Working Group and others to accelerate the learning curve of effective microinsurance operations could be extended to include the development of such an institution, because it is an indispensable missing link in enabling microinsurance schemes to make insurance work for the poor.

The provision of technical assistance

Richard Leftley and Richard Lacasse

The authors appreciate the insights and suggestions provided by Frank Bakx (Rabobank Foundation), Zabid Qureshi (consultant), Karen Schwartz (AAC/MIS), Sabine Trommershäuser (GTZ) and John Wipf (CCA).

Technical assistance (TA) is the provision of expertise on a contractual basis to an organization that needs support. For microinsurance, this could mean assistance with starting a new scheme, launching or improving products, generally upgrading operations, meeting legal requirements or obtaining reinsurance. Provided on either a short- or long-term basis by a variety of individuals and institutions, technical assistance often goes beyond specific technical elements and extends to improving management and governance.

The objective of TA depends on what perspective one has. Donors and policymakers, keen to see a massive expansion of microinsurance, recognize that there is a significant need to build capacity among insurers and delivery channels. Microinsurance providers may seek out technical assistance to expand their product menu, enhance their efficiency or improve their bottom line. As for the TA providers, since this is a new field, they are often interested in developing tools that can be used in different contexts to improve the quality and efficiency of their services.

From the experiences of microinsurance technical assistance providers, this chapter seeks to draw lessons that may help to expand the availability of TA and improve its quality. Although technical assistance is certainly relevant to addressing the meso and macro levels discussed in Chapter 5.1, here the focus is on improving the performance of a microinsurance provider – including both the risk carrier and the distribution channel. The chapter begins by highlighting the importance of technical assistance and then describes the types of TA services commonly offered. The third section categorizes and describes microinsurance TA providers, while the conclusion summarizes modalities and characteristics of quality technical assistance.

I Why is technical assistance required?

The gap between the supply of and demand for microinsurance is enormous. There are few providers of insurance services to the poor, and even fewer that actually provide a useful service. Yet millions, perhaps billions, of low-income households do not have access to efficient mechanisms for managing risks. To fill this gap, microinsurance technical assistance is required to help create new providers and improve the performance of existing ones.

Technical assistance is particularly relevant for microinsurance because of another gap: a competency gap. Insurance companies naturally have insurance expertise, but they typically have a limited understanding of what the poor need and want. At the other end of the spectrum, persons working for civil society organizations often have a good understanding of the low-income market, but lack insurance skills. Technical assistance can help fill this competency gap by facilitating collaboration between the insurance industry and civil society, and enabling them to complement each other's strengths.

When the two do join forces to enter the low-income market, the TA provider can play a key role. Without the input of an independent third party during the product design process, the insurance company's commercial interests are often promoted above those of the distributor or indeed the clients. An experienced advisor is essential to make sure that the products will be technically and financially sustainable, and provide adequate protection to the poor. In addition, technical assistance can help microinsurers comply with regulations, for example on technical aspects of the products, actuarial projections, capital requirements and solvency.

The field of microinsurance is on a steep learning curve. Most existing microinsurers have developed their expertise through trial and error – indeed many errors. As illustrated throughout this book, where insurance companies have strived to serve the low-income market on their own, most have not provided valuable or valued services; where NGOs, MFIs and other civil society organizations have introduced insurance themselves, they have often encountered product design and compliance problems.

The amount of information and extent of experiences today are dramatically greater than just a couple of years ago. By keeping abreast of the emerging lessons, TA providers reduce the likelihood of the wheel being reinvented and errors repeated. They are key disseminators and propagators of good practice and can transfer lessons from one region to another.

2 What does a TA provider do?

Technical assistance is a broad, all-encompassing term. Indeed, TA can be used to address any need or weakness in an institution, as long as the microinsurer is aware that the weakness exists. In fact, the first step in providing technical assistance is often an assessment – a self-assessment or an external appraisal – that identifies the problems that need to be resolved or the opportunities that could be seized. In general, TA is useful 1) when starting a new organization, 2) when introducing a new product and 3) to support the organizational development of the microinsurer.

Technical assistance can play an important role when setting up a new organization. For example, TA providers might be asked to conduct a feasibility study before any formal decisions are made about launching a new scheme. When starting from scratch, it is always helpful to involve people who have experience in starting or implementing microinsurance elsewhere and who are in a position to set up systems and procedures more quickly.

For organizations that want to develop a new insurance product or improve the quality and acceptance of products already on offer, TA can be extremely useful for introducing and maintaining viable, demand-driven services with a minimum of staff resistance. Generally, technical assistance can be used throughout the product development or improvement processes, or to assist with any of the following interventions along the way:¹

1. Assess the market

Assistance may be required to assess client needs and demand, quantify the operational realities, assess potential insurance supply including likely rates available from existing insurers, and conduct a regulatory review to see what options are available (e.g. requirement to become a licensed insurance company or agent).

2. Develop product prototype

Based on the market research and institutional assessment, the TA provider can facilitate the development of a prototype product.

3. Price the product

If management accepts the prototype, the product needs to be priced. In the case of a risk carrier working with a delivery channel, the assessment needs to

¹ Note: This is not a product development flow chart, but a list of items in the product development process where technical assistance can play a constructive role (adapted from Leftley, 2005).

determine what rate the insurer will charge, as well as the delivery costs. The combination of the two is what the client is charged.

4. Develop process maps

External advisors can help design the workflow and paper trail to maximize efficiency.

5. Design operations and marketing materials

Before initiating the pilot test, it is useful to have operations manuals, staff training modules, and marketing materials. The marketing focus should be on the development of effective client education materials and techniques.

6. Configure MIS

The management information system (MIS) needs to be adapted to accommodate the new product. For an MFI, to keep insurance separate from savings and credit activities it would be appropriate to install a separate accounting system as well as a suitable tracking system and claims management package.

7. Train staff

Initial training is required for staff who will be involved in pilot testing (and in some cases client training as well). For existing organizations, strategies for overcoming employee resistance to change need to be carefully considered.

8. Evaluate the pilot

Prior to the pilot test, it is important to establish targets that would be considered a success. The TA provider can conduct a review of the pilot test to assess what adjustments are required prior to rollout.

9. Establish a monitoring system

A monitoring system needs to be put in place to track claims, service standards, efficiency and profitability. TA providers can ensure that the system meets management's need for information while monitoring internationally accepted ratios.

10. Link with insurers and reinsurers

If required, the TA provider could assist in negotiations with insurers or reinsurers. Providing a link with reinsurers is especially useful when the insurance market is reluctant to provide cover for the low-income market or for a particular product line (e.g. health or agricultural cover).

Technical assistance is also quite relevant for organizational development, to assist insurers as they evolve over time. Even for successful programmes, external support can be beneficial in preparing a business plan, reviewing management and administrative processes, strengthening governance practices, improving information systems and so on. Actuarial reviews are especially critical to regularly reassess pricing, reserves and product design features (see *Box 104*). By seeking to professionalize microinsurance providers, technical assistance can help organizations serve their clients better and become more competitive.

Box 104

Actuarial reviews of microinsurance schemes

To determine whether a product is properly priced, insurers usually undergo annual actuarial reviews that compare the claims history (actual claims) to expected claims. This process, known as **experience-rating**, may result in an adjustment to future premium rates depending on the **credibility** attributed to the claims history – the more insured lives, the greater the credibility.

The process of experience-rating not only looks back at the claims history, but also considers how claims trends might be affected in the future. For example at MUSCCO, the savings and credit cooperatives (SACCOs) had paid 2.50 Malawi kwachas per K1,000 of the total savings, shares and loan balances per month for both the life savings and loan protection for many years. When the organization finally brought in an actuary to assess the claims experience, he recommended that rate be increased to K4.25 per K1,000. This significant increase – which was surprising to the board since MUSCCO had been effective in building up reserves – was largely due to the expected effect of HIV/AIDS on future claims experience.

Actuaries also analyse product design features to ensure that they work properly. For example, the Agriculture and Rural Development Center of Catanduanes, Inc. (ARDCI), an MFI in the Philippines with 23,000 clients, had been running an unregistered microinsurance scheme copied from a commercial insurer, complete with a one-year exclusion for pre-existing conditions. However, the MFI's staff members were not trained to properly assess the cause of death. As a result, it was experiencing significant complaints from angry clients whose claims had been rejected. The MFI wanted to retain a similar package, but without the pre-existing-condition exclusion. An actuarial consultant suggested a compromise that included a three-month waiting period and then only 10 per cent of the benefits if death occurred in months four to twelve. This proposal was a huge relief for ARDCI as management realized that it could do away with the exclusion and associated headaches, and still have a mechanism to control adverse selection.²

² The authors would like to thank John Wipf for providing details about ARDCI.

These interventions can be supplied by a TA provider on a one-off basis, through a series of short-term assignments, or during a long-term, on-site consultancy. The appropriate length of the involvement will depend on the type of activity and the budget available, but often better-quality assistance comes from those with a longer-term commitment, either on an intermittent or on-site basis. On-site technical experts might take on the role of manager of the insurance scheme, or manage particular operational aspects, such as underwriting, claims processing or insurance accounting. Another key role of on-site advisors is to train local staff, but this is an expensive approach. The pros and cons of long-term, on-site support are summarized in Table 51.

Table 51

Advantages and disadvantages of long-term, on-site TA support

<i>Advantages</i>	<i>Disadvantages</i>
<ol style="list-style-type: none"> 1. The consultant will have a better chance of understanding client needs, operational constraints and market potential 2. Often leads to smoother project implementation as consultant is able to provide project management supervision 3. Able to consider more complex products and distribution methodologies 4. Increased input on factors such as relevant MIS for the organization 5. More likely to lead to high level of skills transfer to middle management 	<ol style="list-style-type: none"> 1. Local management can become dependent and, in the worst case, fail to “own” the changes introduced by the consultant 2. Often leads to a lower level of understanding among local management as dependence on the consultant grows 3. Significantly more expensive than short-term consultancy 4. The “foreign” consultant can be seen as a threat by local insurance companies 5. Often not required to get a product implemented

3

Who provides microinsurance technical assistance?

To help overcome the tremendous gap between microinsurance supply and demand, and the challenging chasm between risk carriers and potential delivery channels, TA providers have to be experienced persons with technical and business expertise. Since microinsurance is a relatively new field, TA providers usually come from two different backgrounds: 1) microfinance or health experts who have learned about insurance or 2) insurance experts who have learned about the design and delivery of insurance to the poor.

Many different individuals and institutions are involved in delivering microinsurance technical assistance. The main categories include 1) insurance companies or professionals, 2) international technical cooperation agencies, which can be governmental or multilateral and 3) international development organizations, which are non-governmental. The review of TA providers

below is not comprehensive or exhaustive. The details of representative providers are listed here to illustrate the types of organizations and persons involved in providing TA, and their diversity of backgrounds and motivations. Drawn primarily from the case studies, the descriptions of TA providers should not be considered to be endorsements of their services.

3.1 Insurance companies, associations and professionals

If microinsurance technical assistance had a vanguard, two organizations would claim to be in it: CUNA Mutual and ICMIF.

In the 1970s and 1980s, **CUNA Mutual**, the United States-based insurance company for credit unions, has also pursued an international development agenda based on cooperative principles. Before anyone used the expression “microinsurance”, CUNA Mutual had propagated loan protection and life savings products in credit union associations and mutual insurance companies around the world, including MUSCCO, TUW SKOK (Poland) and ALMAO (Sri Lanka).³ Besides TA, CUNA Mutual has also made investments in local insurers and provided reinsurance.

By the time microinsurance became known more widely, however, CUNA Mutual had undergone a strategic rethink and largely withdrawn from the realm of microinsurance technical assistance. Yet its legacy remains, with several cooperative-owned insurance companies (and unregulated schemes managed by apex bodies) still operating in many countries. As described in Chapter 4.1, CUNA Mutual’s strategy was to keep it simple. Since the insurers’ main distribution channel was the credit unions, which lacked insurance expertise, its TA recipients only offered basic products in conjunction with their core services.

What CUNA Mutual did globally for the credit union movement was what, generally speaking, another organization accomplished on a broader scale for the umbrella cooperative movement around the world: the International Cooperative and Mutual Insurance Federation (**ICMIF**), and its regional associations in the Americas, Asia and Europe. Having formally begun technical assistance in 1963, the federation has helped popularly based organizations set up some 25 new cooperative and mutual insurers, besides providing continuing problem-solving guidance to developing insurers within its ranks. Its technical assistance in some cases is coupled with financial

³ The insurance schemes supported by CUNA Mutual were not all “microinsurers”. Many credit unions affiliated with CUNA-supported insurers are employer-based and therefore serve as supplementary coverage for persons working in the formal economy. However, many credit unions do include low-income persons, including those in the informal economy, and therefore CUNA Mutual’s experiences are quite relevant for microinsurers and TA providers alike.

support from its funding arm, Allnations Inc, to assist emerging insurers in raising capital and meeting regulatory requirements.

The federation's regional association for the Americas has had a notable track record of insurance development work. The Americas Association of Cooperative/Mutual Insurance Societies (AAC/MIS) provides technical assistance and grants programmes – funded by USAID as well as the established insurer-members of AAC/MIS – to numerous insurance companies in the region. Many of AAC/MIS' technical assistance recipients over the years, such as La Equidad Seguros in Colombia, have had an interest in reaching out and serving poorer populations. For its 35 popularly based members in Latin America and the Caribbean, AAC/MIS, like ICMIF globally, offers technical assistance, including member-to-member TA, and educational opportunities to new and emerging member societies based on the principles of mutual self-help, democracy in ownership and governance, and equitable sharing of gains and losses.

The TA provided by ICMIF and AAC/MIS is demand-driven, as the association responds to requests from organizations that ask for assistance in forming their own insurance agency, department or company. Both AAC/MIS and ICMIF also assist their members in obtaining reinsurance, often from other network members. For example, ALMAO is reinsured by NTUC Income in Singapore, an arrangement brokered by ICMIF since both are members of the federation.

An emerging player in international development work is the **Rabobank Foundation**, part of the Rabobank Group in the Netherlands. Its focus is to develop awareness of the benefits of cooperative banking and microinsurance. In line with the focus of the foundation, another subsidiary of the group, Interpolis Re, offers expertise to assist local organizations in developing countries in setting up microinsurance schemes – in addition to providing reinsurance. In 2000, for example, Interpolis started supporting Yasiru in Sri Lanka with a package of assistance including funding from the foundation along with TA, information systems and reinsurance.

Interpolis actively participates in the recently created Micro Insurance Association Netherlands (MIAN), which mobilizes Dutch insurance experts, including volunteers from Interpolis, to provide microinsurance technical assistance as part of the company's corporate social responsibility.

Insurance expertise is also finding its way into microinsurance through **actuaries and other insurance professionals** from Europe and North America who have decided to apply their skills in developing-country contexts. For example, CGAP funded an actuarial and management consultant to assist VimoSEWA in India from 2002 to 2004. International actuarial consultants have also worked with Spandana and Yeshasvini in India, Grameen

Kalyan (Bangladesh), CARD MBA (Philippines), TYM (Viet Nam), MUSC-CO and others. This development is particularly interesting because it begins to bridge the gap between those with insurance expertise and those who understand the low-income market. By rolling up their shirtsleeves and getting out into the field, these consultants are creating a new class of microinsurance experts.

3.2 International technical cooperation agencies

GTZ implements development projects on behalf of the German Government mainly for the Federal Ministry for Economic Cooperation and Development (BMZ). After a first pilot project on microinsurance with SEWA in 1994, GTZ expanded its microinsurance technical assistance to other NGOs and MFIs. However, usually GTZ provides its services on microinsurance in the context of larger social protection, health insurance or financial system development programmes.

A vast range of capacity-building and advisory services is provided by GTZ. For example, MHOs in West Africa were supported in conducting feasibility studies, product design and insurance administration and monitoring systems. Government officials, healthcare providers, insurers and NGOs were trained to provide quality health microinsurance in Cambodia and the Philippines. In Tanzania, GTZ enabled community-based systems to create a strong national federation, which was officially recognized by the government as a provider of health microinsurance. In Chile and Paraguay, GTZ supports community-based systems to complement social protection efforts by the state.

The ILO approaches microinsurance technical assistance from two perspectives: 1) assisting financial sectors in becoming more inclusive and 2) extending social protection to workers in the informal economy. Much of the effort is dedicated to research activities (such as this book and the case studies that it draws upon), as well as developing training materials. In addition, the ILO has also provided technical assistance to microinsurance schemes, particularly those that extend health insurance to the poor.

The ILO's STEP programme helps grassroots organizations set up microinsurance schemes with a package of TA, management tools (including MIS software) and funding.⁴ In many of the STEP-supported schemes, the

⁴ Besides TA at the provider level, STEP also works at the meso level, providing technical assistance to build the capacity of federative organizations and support organizations promoting microinsurance. At the policy or macro level, the programme organizes advocacy activities, principally aimed at governments, to raise awareness of the usefulness of such insurance schemes and to promote an environment conducive to their development.

managers had no previous experience with insurance. The TA provider guides the feasibility study, and provides the expertise for calculating premiums and setting up the scheme. Technical assistance also includes capacity-building and monitoring, development of annual work plans, assistance in training material development, accounting and reporting and staff training. Some of STEP's TA recipients include AssEF (Benin), VimoSEWA, Grameen Kalyan and BRAC MHIB.

3.3 International development organizations and consulting firms

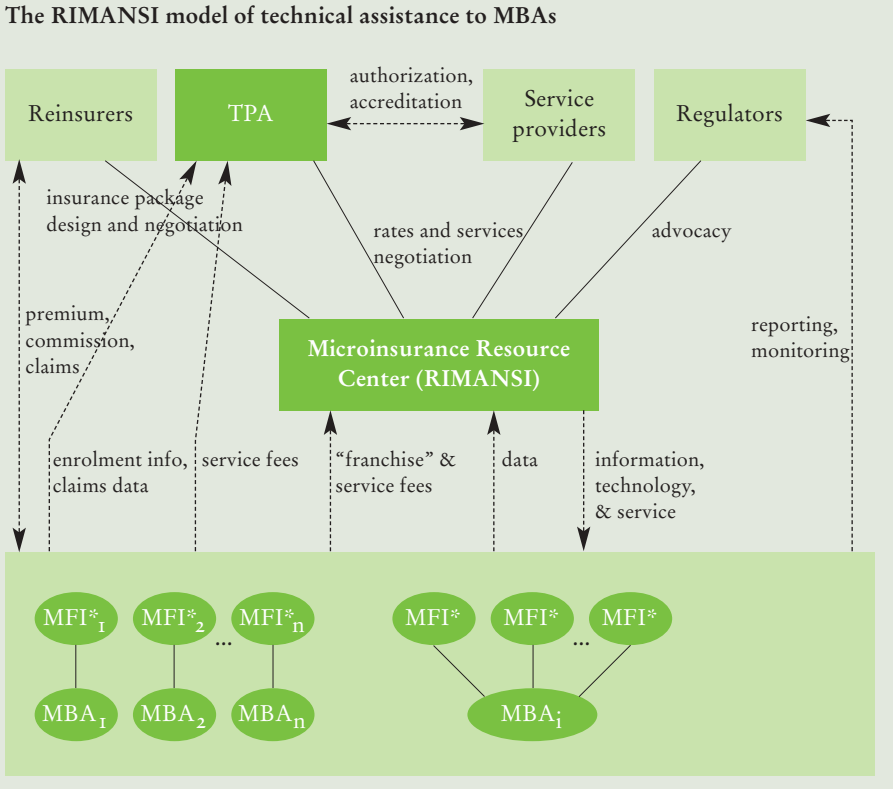
The Canadian Cooperative Association (CCA) provides technical assistance through a Philippines-based actuarial technical advisor who has assisted microinsurers including CARD MBA and the Cooperative Life Insurance Mutual Benefit Society (CLIMBS). Besides actuarial services, the advisor assists with the development of IT systems to facilitate the management of microinsurance data. He also works closely with the board, management and staff. With them, he reviews and addresses the insurance risk, and develops management and control systems.

Together, CCA and CARD MBA have created **RIMANSI** (Risk Management Solutions, Inc.), a microinsurance resource centre that provides technical assistance, administration, assistance with regulatory compliance and reinsurance to MFIs and cooperatives in south-east Asia (*see Figure 37*). In its first year of operation, it supported five MBAs in the Philippines and three microinsurance schemes in Cambodia. Its main approach is to franchise CARD MBA's technology and replicate it.

CIDR is a French NGO involved in various development fields since 1961. It aims at organizing persons in the informal economy to help them assume responsibility for their economic, technical and financial needs. In particular, CIDR works in microfinance, microenterprise development, microinsurance and the management of health services. Through its microinsurance TA, CIDR promoted different approaches in different areas:

- Mutual health organizations (MHOs) organized in regional networks in Benin (20,000 beneficiaries), Guinea (14,000 beneficiaries), Tanzania and Kenya
- Comoros Islands: village-based social security with automatic membership
- Mali: collaboration between a mutual health organization and a microfinance institution
- Uganda: health insurance scheme co-managed with a not-for-profit health-care provider

Figure 37



Microfinance Opportunities is a client-oriented microfinance resource centre. Established in 2002, its speciality in providing TA is the provision of market research. Microfinance Opportunities has pioneered the analysis of consumer demand for microinsurance and assessing risk management strategies of low-income households. To translate the demand research into product design, Microfinance Opportunities often works with the **MicroInsurance Centre**, a specialist consulting firm focusing on improving access to appropriate insurance products by low-income people. In particular, it assists commercial insurers to develop strategies and products to successfully enter the low-income market.

Opportunity International (OI) is a global network of microfinance institutions operating in 29 countries with a loan portfolio in excess of US\$175 million and 840,000 active borrowers at the end of 2005. In 2002, OI became the first microfinance network to recruit an insurance team to help its affiliates develop insurance products. It employs a modified partner-agent model and has developed a range of life, property, disability, unemployment, health, livestock and crop insurance products in nine countries.

Besides serving its own MFI partners, OI has provided some microinsurance technical assistance to external projects including the development of crop insurance products for the World Bank in Africa. In the course of 2005, OI made a strategic decision to establish “The Micro Insurance Agency”, a specialist insurance brokerage providing distribution and administration of microinsurance to a range of MFI networks, SACCOs, cooperatives and rural banks.

SOCODEVI is a specialized NGO formed by a network of cooperatives and mutuals in Canada originating from the insurance and financial sector, agriculture and agro-business, forestry and consumers co-ops. SOCODEVI focuses on the promotion and strengthening of the cooperatives as a tool for sustainable development. For twenty years, SOCODEVI has provided technical assistance in microfinance, insurance, agriculture and forestry to partners in Africa, Latin America and Asia.

In insurance, SOCODEVI’s approach is to set up cooperative and mutual enterprises that offer high-performing, diversified and accessible products adapted to the members’ needs. SOCODEVI helps insurers improve their competitiveness while developing their management and marketing capacities. SOCODEVI’s cooperative development programmes involve volunteers from its own membership, so there is a stronger commitment by the TA provider than just completing an assignment. For microinsurance projects, the consultants come from member insurers, commanding a lot of credibility with the organizations where they provide the expertise. Through the years, SOCODEVI has mostly supported insurance organizations in Latin America, including ServiPerú and Columna in Guatemala.

4 **Conclusion: Providing quality technical assistance**

Despite the diverse nature of these illustrative TA providers, there are some common threads that draw them together. Most organizations fall into the cooperative and mutual camp, which is quite logical since one of the core principles of cooperatives is to support the development of other societies. A second theme comprises organizations that have emerged from microfinance to promote insurance as well. Lastly, the international technical cooperation agencies have a slightly different interest as they tend not to focus just at the institution level, but also strive to deal with relevant meso and macro issues.

On the basis of this list of TA providers and their experiences, and drawing from the literature on technical assistance, it is possible to highlight some preliminary lessons. In general, the process of providing TA requires careful examination to ensure that proper incentives are in place to enhance the quality of the service. The SEEP Network has examined this issue in the context

of microfinance, and identified seven key principles (the 7 Cs) that are necessary to ensure excellent TA (see *Box 105*).

Box 105

The 7 Cs of technical assistance

To derive the maximum benefit from the scarce investments in technical services and to create positive returns on investment in technical assistance, the SEEP Network developed a framework for delivering quality technical assistance. Although its 7C criteria were designed with the provision of TA to microfinance institutions in mind, they have relevance, and are adapted here, for microinsurance providers.

1. Client demand-driven

This principle addresses the need for the TA recipient, the microinsurance provider, to own the TA process and drive the choice of technical services. The principle implies that the microinsurance management team undertakes a self-assessment to define the organization's technical needs and then obtains the technical services required to improve performance.

2. Context

This principle addresses the need to identify the external contextual variables that can influence the choice and effectiveness of technical service delivery, including economic, cultural, political and institutional variables.

3. Concrete results

This principle encourages microinsurers to define and agree to clear results with time limits (and interim steps if appropriate) to be delivered by the TA provider. These deliverables should include concrete outputs for:

- individuals, in terms of their level of knowledge, skills, or attitudes,
- systems (e.g. information or financial), in terms of their performance and/or capabilities and
- the institution, in terms of performance goals related to the technical service.

It is important to note that deliverables should be appropriate for the size, age and capacity of the institutions receiving and providing the technical services.

4. Checkability (indicators to check results)

This principle encourages microinsurers to design and agree on performance measures, or indicators that will verify the delivery of specified outputs by the technical service provider.

5. *Focus on Change (baseline indicators)*

Inseparable from the idea of Checkability, this principle requires a microinsurer to collect baseline information on its own performance to measure the results of technical assistance. Benchmark indicators may include staff attitudes, knowledge levels, skills, and system and institutional capabilities or performance.

6. *Cost-effectiveness*

This principle ensures that cost-effective measures will be used to select and verify the delivery of technical services. The principle encourages microinsurers to measure the results of technical services against their total cost (direct and indirect) in order to discern whether such services are worth the expense incurred.

7. *Clear accountability*

This principle encourages microinsurers to build mutual accountability mechanisms into technical assistance contracts. It emphasizes the need to assign clear roles and responsibilities for each party to achieve specified results, using incentives and/or penalties to ensure that the TA recipient and provider fulfil their commitments to each other.

Source: Adapted from Goodwin-Groen, 2003.

This 7 Cs framework is an effective guideline for improving the quality of technical assistance. Indeed, receivers of technical assistance sometimes complain that the quality and impact of the services did not justify the cost. Often, TA services are supply-driven, with the technical assistance matching the providers' expertise rather than the receivers' needs.

In the process of providing quality TA, some key factors need to be kept in mind:

1. Insurance products must be kept simple and easily understandable.
2. Product benefits should be in line with an affordable premium for the targeted customers.
3. Commitment and strong leadership are required from senior management and the board to accept and implement the needed changes.
4. If the TA recipient requires a long-term intervention, then the TA provider must have a long-term commitment so the two can forge an effective working relationship.
5. Although it may appear efficient, it is not appropriate to promote the same formula or product menu in different countries. While the process of provid-

ing technical assistance may be the same, the results of that process can be quite different depending on the capacity of the TA recipient, its market and the regulatory environment.

6. The TA provider needs a) expertise in the particular technical area and b) the ability to impart that expertise to others, possibly in a context quite different from the one the expert is used to working in. These two qualities can be difficult to find in one individual.
7. TA providers must recognize and respect the absorption capacity of the organization and its staff; a step-by-step or phased approach usually works best.
8. The TA recipients should not only understand what they have to do, but also understand why they have to work differently and be motivated by the new vision.
9. TA providers need to build the capacity of microinsurers to increase the target market's understanding of the benefits of insurance.
10. Effective technical assistance includes continuous monitoring with standards, indicators and benchmarks.

One way to increase the quality of TA, improve accountability and ensure that it is demand-driven is to ensure that the TA recipient actually pays for the technical assistance or at least shares some of the costs. There are a few examples already of multinational insurance companies hiring microinsurance experts to help them develop strategies to serve the low-income market.

However, **funding for technical assistance** often flows from a donor to a consultant or a network organization that then provides technical assistance. The TA recipient may have little say in who provides the services or whether the cost of those services is an effective use of resources. To overcome this problem, some networks such as Opportunity International have required their MFI partners to contribute to the cost of the TA from their own income. In some cases, donor grants have been provided directly to the MFIs, which are then free to choose whether to use an internal TA provider (i.e. within the network) or to access the expertise elsewhere. This type of financing mechanism puts the TA recipient in charge of the process and increases the likelihood that the TA provider will be held accountable.

One strategy for reducing the cost of microinsurance technical assistance is evident in the trend toward **south-to-south services**. Often AAC/MIS serves as a facilitator of technical assistance, linking up the skills of one member with the needs of another. Similarly, the emergence of RIMANSI in the Philippines is an important achievement. Not only is a local TA provider more affordable than international consultants, but it is also more familiar with the context. In West Africa, Développement international Desjardins

(DID) is pursuing a similar approach as it tries to develop the capacity of a local TA provider (*see Box 106*).

Box 106

Technical assistance partnerships: DID and CIF

The *Centre d'Innovations Financières* (CIF) is a technical assistance provider that works with six networks of savings and credit cooperatives in West Africa (FECECAM in Benin, FCPB in Burkina Faso, Kafo Jiginew and Nyèsigiso in Mali, PAMECAS in Senegal and FUCEC in Togo), which include 500 cooperatives and 1.2 million members. CIF has a particular interest in designing new products to meet customer needs.

Développement International Desjardins specializes in providing technical support and investment for the community finance sector in developing countries. It is a component of the Desjardins Group, the largest financial cooperative in Canada.

CIF and DID are technical and strategic, as well as financial partners. By capitalizing on and combining their international and local expertise, CIF and DID have created a formidable symbiosis. Through CIF's knowledge of local conditions, it can understand the unmet needs of cooperative members. In many places, such as Togo, CIF has identified the need for microinsurance products. It is here that the cooperatives and CIF can benefit from DID's insurance expertise. Besides having its own microinsurance experts, DID has also learned a lot about the insurance business from its parent company.

Together, these partners have developed locally responsive, yet financially viable products to be piloted in Togo. By learning from and building on the experience of the pilot, the products will then be mainstreamed across all member cooperatives. Indeed, the costs and risks associated with developing products in this fashion are much lower because other CIF networks and stakeholders can benefit from the experimentation done in a single network.

In addition, by providing technical assistance to a local TA provider, DID is able to create a multiplier effect. With CIF subsequently leading the development of microinsurance in the other networks, the costs are much lower than if DID had provided technical assistance to each network separately.

Source: Adapted from Tremblay et al., 2006.

Another strategy for improving TA and reducing costs has been for networks to **share resources**. For years, AAC/MIS and SOCODEVI have shared consultants and management of technical assistance to achieve common goals in supporting insurance partners in Central and South America. The organizations agreed on strategies for supporting these partners, including exchange of information to improve the follow-up of TA. One remark-

able result of this collaboration was to develop common management tools, set performance standards and jointly seek reinsurance for the TA recipients. The use of common indicators has also allowed for an easier exchange of information and experience between the microinsurers themselves. Many organizations receive technical and financial assistance from multiple donors, encountering problems of consistency of message and recommendations – not to mention duplication of effort. Donor coordination and collaboration, as achieved by AAC/MIS and SOCODEVI, benefit the recipients as well as providers of technical assistance.

A common theme among many of the microinsurance TA providers is the combination of **technical assistance and money**. Grants and investments often accompany the technical assistance for greater impact. Where an investment is made, such as by CUNA Mutual or ICMIF's Allnations, there is a strong probability that the accompanying technical assistance will be of high quality since the TA provider has a vested interest.

Another important link is between **TA and reinsurance**. There have been instances where the local insurance providers have been unable to provide a product or coverage because of their own reinsurance restrictions. If an insurance company has a restriction on its own reinsurance programme, it will limit the coverage it is willing to offer for fear of incurring a net retained loss. A TA provider can provide the connections necessary to negotiate effectively with a reinsurance company to achieve better coverage. For example, when Opportunity International Bank Malawi wanted to offer livestock insurance, it could not find a local insurance company willing to participate as the insurers' reinsurance treaties excluded livestock. OI was able to negotiate with reinsurers in South Africa to allow NICO, a Malawian insurance company, to front the coverage with the risk being carried by the reinsurer in South Africa.

TA providers also have a role to play when the local insurance industry is unwilling to provide coverage because of a lack of technical knowledge. When OI was developing a crop derivative for The World Bank in Malawi, the local insurance companies were initially unwilling to underwrite it as they had no prior experience in pricing similar products. After some discussions with OI's experts, the local insurers formed a pool to underwrite the risk on the basis of OI's actuarial input, product design TA and on-going underwriting support.

A final strategy for maximizing the effectiveness of microinsurance technical assistance is to focus on the **brokering role** of a TA provider. By bringing together an insurer and a civil society organization, the TA provider essentially minimizes the need for technical assistance since the two complement each other in expertise. The TA provider is primarily needed up front

as an interpreter, to speak insurance-ese to the grassroots organization and development talk to the insurer. Once the two start understanding each other, the continuing need for the interpreter – the TA provider – is substantially reduced.

6 Conclusions

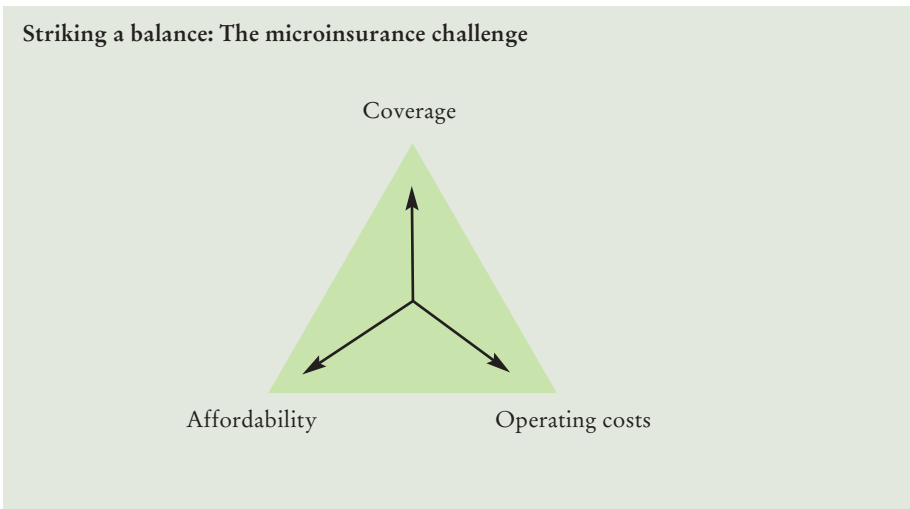
6.1 Strategies for sustainability

Craig Churchill and Denis Garand

The authors are indebted to the following persons for their critical comments and suggestions on this chapter: Felipe Botero (Metropolitan Life), Bruno Galland (CIDR) Alexia Latortue and Aude de Montesquiou (CGAP) and John Wipf (CCA).

As illustrated in the preceding chapters, creating a viable microinsurance scheme is challenging. Whether the scheme covers its costs with the assistance of donors and governments, or from premium revenues and investment income, sustainability ensures permanent access to services. The sustainability dilemma boils down to a trade-off between three competing objectives (see Figure 38). How do microinsurers find a balance between 1) **coverage**, meeting the needs of large volumes of low-income people, 2) **costs**, operating costs and transaction costs for the insurer, and 3) **affordability**, representing the price and transaction costs for clients?

Figure 38 Striking a balance: The microinsurance challenge



Based on experiences from the case studies, this chapter summarizes 12 strategies that can be used to achieve sustainability, divided into three major categories:

1. Limit benefits
2. Focus on efficiency
3. Diversify income sources

The chapter concludes with some observations on management, which underpins each strategy and can make the difference between a scheme's success and failure. As a business develops and grows, and achieves a regular flow of income, it has to balance another set of three competing interests – of **employees** to get the best compensation, of **customers** to purchase the product at the best price, and of “**shareholders**” to receive the best return on their investment, whether in financial or social terms. Success then depends on managing effectively to keep these main stakeholders satisfied.

I Limit benefits

Starting a microinsurance programme is similar to starting a normal insurance company; however, it takes longer to reach viability. Just how long depends on the product, target market and the sustainability strategy. The first approach to achieving sustainability is to limit the benefits offered. Though not a perfect scenario since the insurer cannot provide low-income households with the range of protection they need, insurance with limited benefits can be relatively inexpensive and in any event better than no coverage at all. Basic benefits are also an appropriate starting point. As the target market develops an appreciation for the value of insurance, and as the insurer develops expertise in providing it, benefits can be gradually increased.

I.1 Start with credit life

One of the most affordable products is credit life or loan protection. Apart from providing a limited benefit, as a compulsory product tied to an existing distribution channel, its administrative cost structure should be very efficient with a reasonable spread of risk.

While it is debatable whether these advantages really help the low-income market, credit life should be thought of as a starting point. If microinsurers provide credit life cover at an appropriate rate, they can build a substantial capital base and then expand the benefit package. With appropriate technical help, they can establish a sufficient premium to pay expected claims and administrative expenses, and contribute to a surplus. The provision of credit life can also be used to establish basic insurance management skills, monitoring systems and communication strategies. Once the surplus reaches a pre-determined amount and the microinsurance scheme is financially stable, the funds can be used to increase benefits for the policyholders.

For example, once Spandana had built up sufficient reserves from its credit life product, it expanded benefits to include the death of the spouse and hut insurance, while at the same time lowering premiums. MUSCCO

(Malawi) and CARD MBA (Philippines) are in a similar position to enhance benefits now that they have amassed considerable capital – in the case of CARD, perhaps excessive capital. MUSCCO has built up US\$198,000, while CARD MBA has generated US\$830,000 in surpluses as it has a very efficient administrative structure and the premiums charged are much higher than required.

The “credit life” strategy for sustainability is predicated on using this cash cow to lay a strong foundation, which enables the microinsurer to provide customer-friendly benefits in the future. However, this strategy is only appropriate for lending institutions wishing to get involved in insurance. A major disadvantage is that early policyholders are essentially overcharged, while those who join the scheme later benefit. In addition, because coverage is mandatory, customers may not even know that they have it. Consequently, it does not help to overcome the market’s lack of understanding and its wariness of insurance. To achieve that objective, it would be more useful to start with a “credit life plus” product that provides a payout (i.e. over and above the loan amount) and covers other family members as well. It also may make sense to offer a couple of different options so that, even though it is mandatory, clients can choose between two or three levels of coverage.

Sustainability strategy 1. Start with credit life

Advantages

- Relatively simple to put into place.
- Provides target population with some benefit – at least it is better than doing nothing.
- Creates a clear management focus important for achieving efficiency and viability. Management can learn simple steps before proceeding to more complex insurance offerings.

Disadvantages

- Only covers death risk (and sometimes disability) and provides a very limited benefit.
- Main beneficiary may be the lending institution. Is this insurance really for the MFI?
- Does not help clients understand insurance, nor does it nurture an emerging insurance culture.
- Provides insurance only to debtors, and provides no service to the wider community.
- Early policyholders may be overcharged.

- It may take time to develop the broader coverage required by the target market.
- Management may get comfortable and fail to improve insurance skills or operational efficiency.

1.2

Cap benefits

Another way of limiting benefits is by putting a ceiling on the amount that will be paid out over a period of time. For example, ALMAO's funeral policy covers up to nine lives per household, but only covers two deaths per year per household. Karuna Trust pays for lost income due to hospitalization up to a maximum of 30 days per year. Life savings schemes always specify a maximum benefit; at MUSCCO, the maximum coverage is MK 100,000 (US\$935), while, in Guatemala, Columna's life savings coverage goes up to Q. 50,000 (US\$6,000).

This benefit-capping approach is particularly common in health insurance. TYM goes so far as to only provide a health insurance benefit once during a client's lifetime, and limits that benefit to VND 200,000 (US\$13), which hardly seems sufficient to cover members' needs. While this is certainly not an ideal benefit, it is the best that this informal scheme feels it can provide given its current management capacity and the members' ability to pay.

Although not as severe, Grameen Kalyan and BRAC in Bangladesh both limit the benefit amounts for patients needing treatment from other healthcare providers. Although the vast majority of GK and BRAC policyholders have their healthcare needs addressed at the organizations' own clinics, more severe cases must be referred to hospitals and other specialist facilities. Where this arises, GK, for example, reimburses up to US\$34 for hospitalization due to maternity complications and up to US\$17 for hospitalization due to other complications.

Providing limited benefits reduces claims volatility and hence reduces the need to obtain reinsurance coverage. However, this approach does not solve the basic problem of helping low-income households to cope with large losses.

Sustainability strategy 2. Cap benefits

Advantages

- Capped benefits reduce the premium.
- No need for any reinsurance coverage.

Disadvantages

– The greatest need for insurance is to cover large medical bills; capping benefits defeats one of the primary objectives of health insurance, which is to prevent the poor from having to sell their assets or borrow from a moneylender to receive treatment. Insuring high claims amounts should be affordable if the incidence rate is small.

1.3 Target benefits

If the low-income market cannot afford comprehensive cover, especially for health insurance, then it is necessary to ration benefits, and make some difficult choices regarding what is and is not covered. For instance, the public schemes in Bolivia (SBS) and Peru (SMI) limited their initial benefit packages to the most relevant epidemiological problems of maternal and early childhood health. AssEF and UMSGF clearly list the treatments covered, and do not pay for any that are not. This is necessary not only to reduce claims, but also to educate the policyholders.

Benefits can also be designed to fill key gaps in the existing mechanisms for coping with risk. For example, Karuna Trust's benefits were designed to supplement services for the poor in public health facilities. These people do not need the actual healthcare coverage, but if the policyholder is hospitalized for more than 24 hours in a designated public health facility, Karuna provides Rs. 50 (US\$1.10) per day as compensation for wage loss. This benefit package is very appropriate for workers in the informal economy who might otherwise not seek healthcare, not because of the cost of the care but because of the opportunity costs of not working. Other gaps addressed by the Karuna insurance coverage include pharmaceuticals and ambulance transportation.

It is best to involve the members in choosing the benefits to allow them to make the tough decisions about how much they are willing to pay and for what benefits. For instance, Microcare's customers chose not to include medication for chronic diseases in their benefit package instead of excluding chronically ill persons. This made the package more affordable while being broadly inclusive, and therefore more attractive to the clients (although the chronically ill had to find some other way to pay for their insulin, inhalers and so on).

Sustainability strategy 3. Target benefits

Advantages

- Targeted benefits mean smaller premiums.
- Provided clients' needs are well understood, the scheme can address clients' top priorities.

Disadvantages

- When an insurer limits the benefits, members always want more.
- May not cover illnesses or risks that some policyholders are most concerned about.
- Risk of drop-outs if clients are consistently not covered for risks they face, and if coverage is not clearly understood (although these disadvantages can be tempered by involving the clients in choosing the benefits).

1.4

Focus on big-ticket items

Another way of targeting benefits is to focus only on high-cost, low-probability items such as surgery, letting policyholders pay for their more mundane healthcare costs out of their own pocket. Although this approach reduces the likelihood that individual policyholders will actually benefit from their insurance policy, it also minimizes premiums while ensuring that protection is there when people need it most.

The prime example of this approach is Yeshasvini Trust. For a premium of just Rs. 120 (US\$2.70) per year per adult, the insurance scheme covers more than 1,600 operations.¹ The benefit covers surgery along with nearly all associated costs, including admission fees, bed charges in a common ward, nursing, anaesthesia, the surgeon's charges, as well consumables and medicines during and after the operative period.

The underlying assumption that led to the creation of the benefit package is that poor households cannot afford surgery, which is often lifesaving. Those who pay the full costs of surgery without insurance often further impoverish themselves and their households. Since only a few illnesses require surgery, a large number of households joining together in an insurance scheme can make surgery accessible for those who need it. While this approach undoubtedly benefits policyholders, there are still many expensive treatments that are not covered by the scheme, including hospitalization without surgery.

Sustainability strategy 4. Focus on big-ticket items*Advantages*

- Focuses on major expenses that would force households to sell productive assets, starting a downward spiral further into poverty.
- Provides coverage for large and infrequent risks, lowering the administration cost of dealing with many small claims.

¹ This scheme also has a maximum annual benefit of Rs. 200,000 (US\$4,545), which is sufficient for two of the most expensive operations and some smaller ones.

Disadvantages

- Primary care measures have the greatest impact on reducing overall healthcare expenditure. Funding only the big-ticket items may result in increased cost over many years as the insured delay early cost-effective treatment.
- In the history of healthcare, expenditure on prevention and health-promotion measures has had a far greater impact on reducing total health expenditure and improving the overall health of the population. Some would question the wisdom of insuring big-ticket items that save a few persons, when the same amount could save more lives, for instance if it were applied to a pre- and post-natal care programme.

2 Focus on efficiency

Besides limiting the benefits, the second set of sustainability strategies focuses on minimizing costs through more efficient and effective products, systems and processes.

2.1 Provide member benefits

The member-benefit approach is perhaps the most effective way of minimizing the operating costs for the insurer and the transaction costs for the insured. As the name suggests, the idea behind member benefits is that members of a group, such as a credit union or cooperative, automatically receive specific insurance coverage, usually without directly paying any premiums. A common example is the life savings cover provided by Columna, MUSCCO, La Equidad and other insurers of SACCO networks (*see Chapter 2.3*).

As there are no individual transactions, the operating-cost structure is minimal. For example, for its member benefits, MUSCCO's total administrative expenses were just 15 per cent of premiums (2003), while for its individual sales of a complex product in India, VimoSEWA's administrative expenses were 97 per cent of premiums (2004). In the developed insurance market, distribution costs are generally the major item in administrative expenses and therefore, by eliminating them, the member-benefits approach can make insurance much more affordable.

To offer a member benefit, the institution has to have another revenue source to pay for insurance. For example, Yeshasvini Trust collaborates with milk-producing cooperatives that pay premiums on behalf of members by deducting the amount from their monthly milk-production income.

In the case of life savings, the credit unions pay a lower interest rate on the savings to be able to pay the insurance company to provide the benefit.

This reduction in interest on deposits may make the savings product uncompetitive and cause client desertion, or it could be marketed as an attractive benefit that could cause members to increase their savings balances, since the greater the balance, the greater the benefit (up to a maximum).

Sustainability strategy 5. Provide member benefits

Advantages

- A cost-effective method of covering the whole membership.
- As long as the benefit is reasonably low, there will be little adverse selection.
- Minimizes administrative costs.
- Can be an attractive feature which may increase membership.

Disadvantages

- Only members can receive cover.
- The level of cover may not meet the needs of the target population. For example, the client may withdraw from the savings account to pay for treatment costs prior to dying, resulting in inadequate benefits.
- The insured may not be aware they have benefits. If benefits are not claimed, this will distort data and lead the organization to believe it has better claims results than in other programmes where members know they have insurance.

2.2

Use low-cost premium payment methods

Since low-income households have difficulty paying annual premiums in one lump sum, to make premium payments fit better with the cash flows of low-income households, microinsurers have had to innovate. The most common approach is to increase the frequency of premium payments so they are in smaller amounts. Unfortunately, this is likely to significantly increase transaction costs, thus making products more expensive – more affordable and yet more expensive at the same time!

As described in Chapter 3.3 and elsewhere, VimoSEWA has an alternative solution to the lump-sum payment problem that simultaneously decreases the transaction costs. It offers a fixed deposit method whereby the interest from the savings account pays the insurance premium. This arrangement has the advantage of providing semi-permanent insurance with essentially no transaction costs once the total amount has been deposited. However, the poor find it hard to save up enough to put into the account and it is difficult to get policyholders to increase their deposit amount when interest rates decline or premiums increase. Only 25 per cent of VimoSEWA's 120,000 policyholders use the

fixed deposit method to pay premiums; the rest pay through an annual marketing and renewal campaign, which partly explains why the associated administrative costs are still quite high.

Another low-cost premium payment method is through automatic deductions from the policyholder's savings account. Instead of relying on physical transactions, which are expensive for the insurer and policyholder alike, electronic transactions can minimize the cost of collecting premiums. For this to be an option, however, low-income households must have access to savings accounts.

In the Philippines, G-Cash has recently been allowing financial transactions via cell phone at a cost of 1 peso each.² This can be a very cost-effective method of communicating premium due and collecting premiums as clients do not have to pay transportation costs and the insurer receives data quickly and efficiently. Indeed, additional innovation is required in this area to enhance efficiency further. Perhaps technology will provide new solutions.

Sustainability strategy 6. Use low-cost premium payment methods

Advantages

- Virtually eliminates transaction costs.
- Fixed deposit method provides semi-permanent coverage for the policyholder, and minimal lapses for the insurer.
- Lower costs make it possible to offer greater benefits.

Disadvantages

- Clients need to have access to savings accounts (or cell phones).
- For the fixed deposit approach, it can be difficult for the poor to amass the deposit amount, and difficult to convince policyholders to increase the amount if premiums go up.

2.3 Rely on inexpensive distribution systems

One of the major reasons why insurance companies cannot reach low-income markets is their lack of appropriate distribution systems. However, as the experience with the partner-agent model illustrates, grassroots or community organizations can be inexpensive and effective insurance distribution channels. When considering this approach, the most logical delivery agents are microfinance institutions, since they already have savings and credit transactions with the poor. Similar experiences are found in mainstream

² The authors wish to thank John Wipf for providing the details about G-Cash.

insurance where very efficient *bancassurance* products can reach a large number of policyholders.

However, to really expand the availability of microinsurance, it is also necessary to look beyond financial institutions as possible delivery agents. Yeshasvini uses the existing cooperative network to sell health insurance, collect premiums and distribute photo ID cards. Likewise, the partnerships between insurance companies and retailers in South Africa (see *Chapter 4.6*) seem like potentially inexpensive mechanisms to extend insurance to the poor.

For microinsurance, a key aspect of inexpensive distribution is to have minimal screening and underwriting requirements. This is possible with group policies whereby everyone who is part of the group and meets the age criteria is eligible for insurance cover. Even with individual policies, it is possible to have minimal underwriting up front (perhaps just a signed declaration of good health), shifting the burden to the claims process. This back-end scrutiny is more cost-effective since it applies only to those few people who claim instead of the huge volumes of people who join the scheme.

Sustainability strategy 7. Rely on inexpensive distribution systems

Advantages

- Can use the existing distribution structure.
- Easy to implement.

Disadvantages

- Overloaded staff of existing system may not clearly explain the insurance benefits.
- The risk carrier may not acquire the necessary in-depth understanding of the target market.
- Only appropriate for basic insurance cover.

2.4

Control costs

A key strategy for controlling costs is to enhance efficiency by differentiating requirements depending on the size of the insurance policy. For example, simple microinsurance products can be handled by less expensive employees. Or if the sums insured are below a certain amount, then a more streamlined, less expensive approach can be taken. At Delta Life, if a policy is for more than US\$2,000, then the applicant must undergo a medical examination; for amounts below US\$2,000, only a health declaration is required. Similar adjustments can go a long way towards making the smallest policies more sustainable.

The community-based model often relies on volunteer labour of its members as a cost control strategy (*see Chapter 4.3*). This approach has been particularly effective in making it possible for many small schemes to cover their costs in a short period of time, but it is not a long-term strategy; volunteers tend to become de-motivated resulting in high turnover.

In health insurance, minimizing claims costs is a major challenge. Organizations that manage their own healthcare providers, such as ServiPerú, BRAC and Grameen Kalyan, can exert a greater influence on healthcare costs. At ServiPerú, for example, doctors' salaries, usually a fixed cost, are rendered variable by linking remuneration to the number of consultations provided. If properly managed, such a capitation compensation system can provide a direct link between income and expenses.

In addition, regardless of who provides the healthcare, microinsurers must make sure that appropriate treatment protocols are followed, such as only prescribing pharmaceuticals that are actually needed (a challenge since consumers always want pharmaceuticals, even if they are not necessary), providing generic pharmaceuticals where possible, and not conducting unnecessary tests – BRAC's MHIB has made significant progress in this regard.

Although these approaches are relevant for conventional insurance as well, one microinsurance-specific cost-control strategy is to appeal to the members' sense of solidarity in the expectation that they will voluntarily refrain from over-usage. For example, as a cooperative, ServiPerú asks its members to avoid excessive or unnecessary use of services so that the company can keep prices low. While such an approach will undoubtedly engender a certain amount of free-riding, it will probably be less severe in a mutual or NGO than it would be in an organization driven by profit.

Another element in keeping costs down is loss prevention. Microinsurers can reduce claims costs by providing health education that encourages people to eat better and obtain treatment early, and by health promotion campaigns, for example providing insecticide-treated mosquito nets in areas of high malaria risk to and developing access to clean water supplies (*see Chapter 3.9*).

Such prevention campaigns do not necessarily need to be conducted by the insurer. Indeed, strategic partnerships are a particularly useful way of stretching the budget. For example, several microinsurers collaborate with organizations raising awareness about HIV/AIDS or with government immunization campaigns to provide valuable services to their members at a limited (or no) cost, while striving to reduce claims.

Sustainability strategy 8. Control costs

Advantages

- Differentiated processes, with more streamlined requirements for small policies, appropriately balance costs and controls.
- With proper guidance, many healthcare providers can reduce costs without adversely affecting quality; in fact, clear treatment protocols can reduce costs, and improve the quality of healthcare and service.
- Small investments in prevention can often reap significant returns in the form of lower claims, especially if implemented through mutually beneficial strategic partnerships.
- Prevention campaigns enable policyholders who do not make claims to receive some benefit from the scheme.

Disadvantages

- Dependence on volunteer labour is not a long-term solution.
- Heavy downward pressure on the salaries of insurance and healthcare providers could result in high staff turnover and poor-quality service.
- Reliance on solidarity to minimize claims and insurance risk becomes less effective as the organization grows.

2.5

Buy benefits in bulk

Another way to keep claims costs down is for the microinsurer to negotiate with the benefit provider to get a better deal. For example, ServiPerú's cover includes a funeral benefit. The organization has negotiated a discount from associated funeral service providers in exchange for bringing in large volumes of business. Consequently, low-income households have access to a funeral of the same quality for less money by going through the insurer.

Yeshasvini followed the same strategy. Given the significant over-capacity in the local hospitals and clinics, the Trust was able to persuade its network of providers to agree to fixed prices for operations 30 per cent below the average price. The healthcare providers agreed to the lower rates because the insurer will actually pay and because they want to increase the utilization rate of their facilities and staff.

Sustainability strategy 9. Buy benefits in bulk

Advantages

- Can make benefits more affordable.
- Advantage for service providers (e.g. clinics, funeral parlours) as they receive a certain “guaranteed” clientele in exchange.

Disadvantages

- Only appropriate when benefits are provided in kind.
- Providers of in-kind benefits may deliver poorer quality services to the insured since they are being paid less.
- The strategy relies on use of excess capacity, which may not always be available.

3 Diversify income sources

One problem in providing insurance to the poor is that they may not be able to afford it, even if the benefits are small and the operating costs are kept to a minimum. The third general approach to making microinsurance sustainable is to diversify income sources so that low-income people only pay for a portion of the costs. This approach is common among the traditional financing mechanisms of social health insurance, whereby financing is based on wage-related and bipartite contributions shared between the employer and the employee, such as that used by Bienestar Magisterial in El Salvador.

However, such an approach can only work in the formal sector. For workers in the informal economy, more creative strategies are required. Some microinsurers become involved in unrelated income-generating activities. Microcare, for example, has a number of contracts for software development and teaching computer skills, which are unrelated to providing health insurance, but they help pay the rent. Yeshasvini is selling advertising on the back of its ID cards to bring in additional revenue. Other ways of diversifying income sources are discussed below.

3.1 Cross-subsidize from other products or markets

One strategy is to subsidize the premiums from other, more profitable products or market segments. Indeed, for a microinsurance scheme to be considered as constituting social protection, it should have a redistribution function from the not-so-poor to the poor.

For example, Grameen Kalyan and BRAC's health insurance schemes serve the broader communities in which they operate. They charge higher premiums for the non-poor to be able to minimize the premiums for low-income community members. Penetration of these higher-income populations is intended to help the plan achieve viability by bringing in more revenue, although the schemes are not quite there yet. In 2003, 10 per cent of BRAC's insureds and 13 per cent of GK's were non-members, providing 18 per cent and 15 per cent of premium revenue respectively. Both organizations have learned that greater effort is required to increase the participation of the non-poor and to avoid adverse selection with this market segment.

Tata-AIG intends to follow a similar strategy. Once its micro-agents have exhausted the market that they can serve easily, they will be taught how to offer more expensive products to higher-income clients. VimoSEWA adopted this approach in 2001, introducing a new benefit package with higher sums insured targeted at higher-income customers. However, sales for this product were quite slow and after two years, VimoSEWA abandoned the strategy. It realized that its existing distribution mechanism was not particularly effective in serving the non-poor, a market where SEWA's brand was not as powerful. In addition, efforts to move up market distracted management from achieving viability in the low-income market.

To extend coverage to the poorest members of the community, the MHOs promoted by UMSFG also intend to cover the destitute when the organizations are in a strong financial situation. However, a major challenge to offering sliding-scale premiums is that the distinction between those who can and cannot pay premiums is not easy to make. In the Forestry Guinea area where UMSFG operates, anybody can become destitute.

This sustainability strategy is also appropriate for commercial insurers serving the low-income market since they naturally have a range of other business lines. For these insurance providers, there is a risk that they will try to generate short-term profits from the poor. Instead, the cross-subsidizing approach can be justified, even to shareholders, if the insurers adopt a long-term view of this market and strive to cultivate customer loyalty in the expectation that these policyholders will be profitable in the future. Indeed, the primary goal today should be to develop an insurance culture in the low-income market, whereas a strategy of maximizing short-term profits is likely to undermine that objective.

TUW SKOK's approach was different because its two market segments were the credit unions and their members. The insurer initially focused on corporate policies for the credit unions, including deposit insurance, coverage for fire and robbery, and fidelity bonding. After it had saturated its corporate market, TUW SKOK turned its attention to meeting the needs of

credit union members. Most importantly, the insurer only began going downmarket once it was in a financial position to do so. Although it is unclear to what extent its member policies are now subsidized by the corporate insurance, TUW SKOK's microinsurance certainly benefits from the fact that the credit unions represented a large captive market for its corporate services.

Sustainability strategy 10. Cross-subsidize from other products or markets

Advantages

- Redistribution is a core element of social protection systems.
- Market diversification increases the security of microinsurance by spreading risk and increasing volumes of insureds.
- Increased volumes should result in increased efficiency, if well managed.
- Can reach sustainability sooner.

Disadvantages

- Reaching a higher-income market may require a different, more costly distribution system.
- The microinsurer may not have the correct brand image to attract higher-income clients.
- The natural tendency with all insurance operations is to drift to higher-income markets over time, as they are usually more profitable. This strategy requires strong governance to maintain focus on serving the needs of the poor.
- In a competitive market, other insurers may have more efficient distribution systems for higher-income populations.
- In a mutual organization, those providing subsidies may be elected to the governing body and change this policy.

3.2

Use an endowment fund to subsidize operations

Another source of compensating revenue could be an endowment or capital fund, from which investment earnings could contribute to operating costs. For this to work, the insurer has to have a significant amount of money and investment opportunities that generate decent returns. Some investment earnings would have to be ploughed back into the fund so it could grow in line with inflation to maintain its purchasing power. It would also be important for the management of the fund to be transparent to ensure that the money is not used elsewhere.

Grameen Kalyan and VimoSEWA have both received endowment grants for this purpose. For VimoSEWA, GTZ provided a capitalization grant in the early 1990s as a strategy to defray administrative expenses. This fund served its purpose as long as the number of insureds remained at around 30,000. However, when membership grew to 90,000, the income from the invested endowment fund was no longer sufficient. Grameen Kalyan's endowment fund was provided by its parent organization to establish health microinsurance. If the scheme were expanded to serve all of the communities where the Grameen Bank operates, however, the fund would not generate sufficient income to cover operating shortfalls.

Sustainability strategy 11. Subsidize from an endowment fund

Advantages

- Increases the value of the insurance programme.
- Provides financial flexibility to target and serve the poor and destitute.
- Provides stable funding for the scheme to plan its future.

Disadvantages

- Who provides the original endowment? It would be difficult to endow many microinsurance programmes or have a large impact on the poor.
- Large endowments require good governance to ensure that they generate earnings and are not diverted to other uses.
- A growth in the covered population may result in deficits if the endowment does not grow at the same pace.
- Even with a stable population, the endowment fund has to generate returns at least at the rate of inflation to maintain its purchasing power.

3.3

Access government subsidies

Microinsurance schemes that emerge from the social protection perspective are either financed in whole or in part by government funds, or a strategy for sustainability is to gain access to these subsidies eventually. For example, the health insurance initiatives of SBS (Bolivia), SMI (Peru) and SI (Paraguay) were all started by the public sector with government funding to extend healthcare to specific high-risk market segments. Other schemes, such as UMSGF, AssEF and Karuna Trust, have benefited from indirect government subsidies. The costs of the healthcare services used by members of these organizations are kept artificially low by subsidies from the government.

A major disadvantage of this approach is that it is vulnerable to political interference. The SBS and SMI both experienced major upheaval when new governments, with different priorities, were elected. Consequently, it is hard

to count on long-term or permanent subsidies from the government. When subsidies are discontinued or decreased, microinsurance operations can experience considerable problems. For example, Yeshasvini received a direct government subsidy in its first two years of operation, which was helpful in providing good benefits at a very low cost. In its third year, when the government subsidy disappeared, the premium had to be doubled, resulting in a renewal rate of only 43 per cent.

Sustainability strategy 12. Access government subsidies

Advantages

- Healthcare should be seen as a human right, and therefore it is entirely appropriate for governments to channel resources to facilitate access for those who cannot afford to pay the premiums themselves.
- Microinsurance can be a cost-effective vehicle for governments to deliver benefits to the poor.

Disadvantages

- Government bureaucracy may not provide timely payments, creating a strain on the microinsurer's cash resources.
- A change in government policy may result in an abrupt cancellation of the subsidy.
- Governments may seek to impose certain methodologies that are not in the interest of the implementing organization.

4

Good management

None of these twelve strategies for sustainability are appropriate in all circumstances, and all have drawbacks. The challenge is to find ways of combining selected strategies in an approach that makes sense for each particular microinsurance scheme. Consequently, the bottom line for success in microinsurance is the same as for any other enterprise: the most essential strategy for sustainability is good management.

Among other things, microinsurance managers must have appropriately-skilled employees in place, realistic product pricing, a sound business plan, timely and reliable management information, and possibly reinsurance if required (*Chapter 5.4*). They also need boards that know how to manage managers effectively (*Chapter 3.8*). As many of these elements are not in place in organizations intending to offer microinsurance, it would seem logical to start with a focused or limited insurance benefit. When appropriate skills and systems have been established, the insurance programme can be expanded.

As with other businesses, managers need a business plan that helps them stay focused on delivering high-value protection at the lowest possible cost. Before expanding benefits and enhancing protection, managers must understand the implications. To do so, managers need tools to allow them assess the options, and to weigh the advantages and disadvantages of higher premiums, lower benefits and so on, ideally in consultation with current or prospective policyholders. Managers also need an information system to track progress towards achieving the goals in the business plan.

As mentioned above, a key aspect of this plan is to define a balance between appropriately compensating employees, giving customers the best product and ensuring that shareholders receive an appropriate return on their investment. This trade-off is simplified if the interests of the parties are aligned. For example, for insurance provided through cooperatives (*Chapter 4.1*), the clients are the shareholders. In the community-based model (*Chapter 4.3*), the employees are often clients and owners.

The importance of having appropriate expertise among the staff, management and board cannot be over-emphasized. Some microinsurers do not have a good grasp of what they are doing or are not paying sufficient attention to their microinsurance activities to even know whether they are succeeding. To be managed effectively, microinsurance should be seen as an independent activity – separate from credit and savings and from conventional insurance – so that management can assess its viability and potential and deploy appropriate expertise to allow it to achieve that potential. In this respect, the community-based model has the advantage of only focusing on microinsurance.

Microinsurers do not have to have all of the required expertise in house, as long as they have access to it. Community-based or mutual schemes accomplish this objective through federations, with second-tier organizations maintaining technical expertise that can benefit many smaller, primary-level organizations. Partnerships between organizations with different types of expertise are a particularly effective strategy. If there is a lack of insurance skills, technical assistance can assist in achieving sustainability. As discussed in *Chapter 5.5*, various international organizations provide technical assistance to microinsurance programmes, as do many independent consultants. If international expertise is too expensive or not readily available, fledgling microinsurance schemes might also consider local insurance talent.

While expertise at the head office or federation level receives most of the attention, for microinsurance schemes to be sustainable, they need to have policyholders, many policyholders. Volumes are critical to the success of microinsurance schemes. So if they want to attract and keep customers, microinsurers need to have effective sales and service functions, and a good reputation for customer service. Indeed, microinsurance providers have to

build up trust among their client base by clearly providing value. In short, the frontline people need to know what they are doing and need to make a good job of it. Consequently, greater investment in training frontline personnel is often warranted.

Well-managed insurance companies usually use reinsurance to manage risk, although reinsurance is not necessary in all situations. Some of the larger insurance companies that are involved in microinsurance, such as AIG Uganda, Madison, Delta Life and La Equidad, do not purchase reinsurance for their smallest policies because they cover many people for small sums over a large geographical area. However, microinsurers without significant reserves and without portfolios diversified between traditional and microinsurance would be well-advised to explore reinsurance arrangements (or at least insurance for catastrophic losses).

Last but not least, good management means using available opportunities and confronting imminent threats effectively. It is an art and a science. Though there are some business fundamentals to keep in mind and respect (such as the solvency ratio and capital levels required to meet obligations to policyholders), survival often depends on problem-solving that calls for judgement. Judgment can be better-informed by the use of industry standards and benchmarking, which for microinsurance is just beginning to emerge (*see Chapter 3.10*). In addition, good judgement comes from experience, and experience comes from bad judgement. It is hoped that from a review of the experiences – good and bad – of other microinsurers, throughout this book and in the case studies, current and future microinsurers will gain wisdom and avoid repeating the mistakes of others.

6.2 The future of microinsurance

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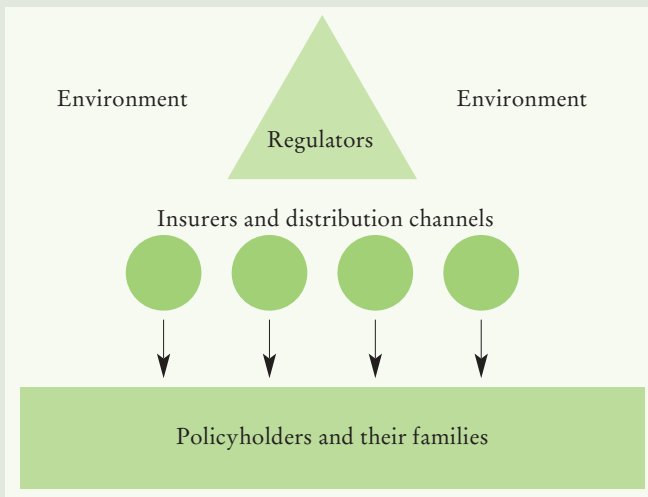
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Considering the future of microinsurance involves looking at the whole picture, which includes 1) current and potential policyholders and their families, 2) the range of different insurance providers and their distribution channels, 3) the insurance regulators and supervisors and 4) the general environment in which all of these interact (see *Figure 39*).

The future success of microinsurance depends on achieving prudent, profitable and continuous growth and development. What will be the development lifecycle for microinsurance? How long will it be? Some say that microinsurance is still at the conceptual stage and a good case can be made for this perspective. However, for the men and women out in the field today, whose efforts have been the raw material for this book, microinsurance is quite real, even if it is still early days. Their hopes for the short-to-medium-term future are the focus of this chapter.

Figure 39

Perspectives on the future



The goal of microinsurance is to make appropriate, affordable risk-management products available to the poor, to help support their economic development and to enable them to achieve financial freedom for themselves and future generations. Microinsurance complements and enhances the effectiveness of informal coping mechanisms, and supplements statutory social protection schemes where they are available.

Chapter 1.1 summarizes the many challenges that inhibit the development and expansion of microinsurance; the subsequent pages are filled with numerous examples of how schemes are overcoming them. However, a number of further obstacles must be faced if insurance markets are to become significantly more inclusive. To massively increase the outreach of insurance services to low-income households, and to deepen penetration to reach those who are even more vulnerable, it is necessary to tackle these challenges (*highlighted in Table 52*). This chapter summarizes some of the solutions that need to be considered to expand the availability and enhance the quality of microinsurance.

Table 52

Continuing challenges that limit the expansion of microinsurance

<i>Category</i>	<i>Item</i>
Clients	<ul style="list-style-type: none"> – Providing effective client education – Cultivating an insurance culture in the low-income market – Satisfying an unmet demand for new products – Reaching the most vulnerable
Providers	<ul style="list-style-type: none"> – Building staff capacity – Strengthening management – Enhancing efficiency – Finding the right business model and delivery channels
Regulators	<ul style="list-style-type: none"> – Removing regulatory obstacles – Adopting a market development agenda – Recognizing informal schemes where appropriate – Developing systematic and comprehensive approaches
Environment	<ul style="list-style-type: none"> – Improving healthcare facilities – Generating and using key insurance data – Strengthening financial markets – Creating stable macroeconomic conditions – Preparing for catastrophic risks

I Microinsurance customers of the future

Microcredit has had an important impact on the ability of poor people to rise above the poverty line. Although the development of microinsurance is more recent, preliminary and anecdotal evidence suggests that it can be an important factor in enabling people to remain above the poverty line. By providing protection against certain perils, microinsurance serves as a natural complement to other financial and social services for the poor. For it to fulfil its potential, it is necessary to develop an insurance culture among the low-income market, as well as to introduce products that meet their primary needs, particularly for those who are most vulnerable.

I.1 Education and culture

Yet the demand for microinsurance requires some coaxing. The case studies noted that greater efforts need to be invested in market education so that potential policyholders understand and appreciate the value of insurance. In fact, successful insurers in developed markets continue to provide their clients and the general population with education on certain topics, leading to improved underwriting experience and customer loyalty. There is certainly a need to develop better pedagogical tools to convey the usefulness of insurance to an illiterate or uneducated market. To make a significant impact, however, client education is insufficient. Rather, stakeholders in the development of microinsurance – including providers, policymakers and donors – need to cultivate an insurance culture among the poor.

An insurance culture is a prerequisite for the success of microinsurance. In many developed countries, it took generations before people commonly turned to insurance to address their risk-management needs. Microinsurance providers will help build the culture of insurance when they serve their clients' needs in a fair and equitable way. The product is the starting-point: clients need to know that they have cover and they need to witness the regular provision of benefits.

Paying a claim – delivering on a promise – is arguably the single most important opportunity to reinforce the value of insurance, and therefore claims need to be handled efficiently and appropriately. Too often, benefits are not delivered as promised and this leads to an anti-insurance culture. Many microinsurance programmes operate in these anti-insurance cultures and struggle to counter the prevailing sentiments.

The evolution of attitudes to insurance will be affected by the ability of providers to continuously improve processes, services, benefits and costs for clients. Governments and civil society can contribute to the development of

such a culture through educational programmes. This culture is reinforced when associations and employers begin offering insurance as membership or employment benefits. In developed countries, the growth of an insurance culture has been further supported by the prevalence of obligatory, government-mandated cover such as third-party liability cover for vehicles. Many people's experiences with these products have helped them to understand insurance, and in some cases encouraged them to seek out voluntary products as well.

For low-income persons in developing countries, the relevant parallel experience could come from credit life insurance provided through microfinance institutions. If MFIs can ensure that their clients have a positive experience, the poor may be more interested and willing to voluntarily purchase other insurance products. Consequently, there should be significant cause for concern when credit life is not taken seriously by MFIs (or their risk carriers) and when efforts are not made to ensure the poor have a positive experience with insurance. Every late payment or summarily rejected claim and every instance of opaque pricing or misinformation about the scope of cover, will add to the time it takes to foster an insurance culture.

To maintain a culture of insurance, providers should strive to serve customers throughout their lives rather than getting them on board and then neglecting their changing needs and circumstances. Lack of attention from the provider is a key cause of high lapse rates and gaps in coverage associated with many microinsurers. Efforts to minimize lapses and non-renewals should include using appropriate premium payment and financing mechanisms, as well as market education and marketing approaches that avoid misdirected and self-serving sales incentives. When microinsurance markets reach a stage where people really understand and appreciate what they are buying, lapses and non-renewals will become less frequent.

1.2

Product evolution

Insurance for the poor needs to develop as the demand for those services evolves. Health cover is the next priority, especially in countries where the governments cannot adequately address the healthcare needs of their citizens. Soon, there may be growing demand for long-term, retirement insurance or old-age pensions, as well as for disaster, housing, and in some areas, livestock and agricultural insurance. These are risks that cannot be managed by savings and credit alone. If microinsurance providers cannot keep up with these demands, they may stifle the development of an insurance culture as low-income persons lose confidence in risk-pooling mechanisms.

Insurance products sold through organizations that potential policyholders trust could also help develop positive attitudes. An insurance culture will emerge only when it is supported through word-of-mouth communication that promotes and spreads awareness of insurance. The combination of a trusted intermediary and word-of-mouth communication may be why many credit unions have been effective in generating an insurance culture among their members.

Microinsurance products that respond appropriately to potential policyholder needs and demands will help to generate an insurance culture. The key strategy to achieve this goal is to involve policyholders (or prospective clients) in the process of making hard choices between benefits and price. Tools that enable clients to see the trade-offs and voice their preferences will go a long way towards appropriate product design.

A long-term, multi-generational outcome is an enticing reason for insurers to enter this market, even though it is incompatible with the short-term perspective of most companies. In developing countries, millions of today's poor households will be tomorrow's middle class. Historically, the measure of success most revered among large multi-line insurance companies is the ability to build lifetime relationships with their clients, even multi-generational ones, providing products and services to cover changing needs throughout the policyholder's life. This is common knowledge to insurance sales agents who rely on referrals for their business and is evident in the multi-line companies that monitor the number of products per customer or household.

The overriding objective of microinsurance is to enable low-income people to protect wealth and achieve some level of economic security. Helping customers to achieve these goals also creates an ideal market for patient insurers; the long-term market potential is huge. Furthermore, brand loyalty is high in this market segment, which makes this argument that much more compelling.

In the long term, microinsurance policyholders will become more knowledgeable about insurance. They will recognize the potential for insurance to address some of their risk-management needs, and they will seek out such cover. They will understand the different risks and capabilities of insurance providers and will be able to make appropriate choices and decisions. Low-income consumers will push the insurance providers to offer the products they want. Microinsurers today have an obligation to help their clients become more knowledgeable, while preparing themselves to serve a more sophisticated market.

The more the target market understands insurance, the more aware they will be of the limitations of market-based solutions. This recognition will

also help empower low-income communities to demand publicly-provided social protection services – after all, social security is a human right. Plus, there will always be a market segment that contributory insurance schemes cannot reach – the chronic or hard-core poor – which must be covered by government programmes. The ongoing challenge in the development of microinsurance is to determine where that frontier lies. How far can the envelope be pushed? What segments of the market could ultimately be reached through continued improvement in delivery mechanisms and efficiency? Similarly, how can microinsurance distribution mechanisms enhance access to government-provided social protection schemes?

2 Microinsurance providers of the future

The second set of challenges that need to be addressed involves the providers themselves. These issues fall into three categories: 1) building the capacity of management and staff, 2) enhancing efficiency, including the use of technology and 3) finding a business model that works for all stakeholders and balances short-term viability with long-term growth.

2.1 Building capacity

Since microinsurance is a relatively new endeavour, it is not surprising that there is a need to build up the capacity of providers. While the case studies indicate that some effort should be channelled to improve existing providers, to fill the enormous access chasm, investments also need to be made in new delivery channels and perhaps in creating new insurers.

The capacity challenges exist on two levels: field staff and management. In general, the field staff associated with the distribution channel – the agents selling and servicing the policies, or the managers of mutual schemes – require additional expertise in sales skills, insurance basics, adult education techniques and customer service. Just as important as the skills, however, is creating a work environment that allows schemes to retain qualified personnel. Currently, many microinsurers and their distribution channels experience high turnover of frontline personnel. Consequently, there is a great need to consider the compensation, incentives and career development of those who have the expertise of selling and servicing insurance for the poor.

As discussed in the previous chapter, building the capacity of management remains a significant challenge. The requirements for managers of informal schemes that may one day become formal, however, are quite different from those for managers in regulated insurance companies considering the low-income market opportunity. The latter need a crash course in under-

standing the needs of the poor, recognizing that microinsurance has some unique characteristics that require more than just smaller premiums and sums insured. The experiences of AIG Uganda and Madison Insurance illustrate that corporate insurers have been reactive, responding to requests from their distribution channels. Tata-AIG's approach of proactively designing specific measures for the low-income market could be a more appropriate tactic for corporate insurers.

In contrast to formal insurers, the managers of informal schemes have a much greater appreciation of the needs of the target market and are more receptive to adopting unconventional approaches since they are not rooted in mainstream insurance practices. However, they tend to have limited education and experience and therefore require more assistance with basic management and insurance skills. To assist these managers, and to support the dramatic expansion of microinsurance products, there is a great need for basic management tools, suitable information systems and software for business planning and modelling. Investors and donors must be careful, though, in their attempts to assist management of informal schemes. Insurance is a business of numbers and any "insurer" should be aiming for a large and diverse client base. It is important that investments be made in organizations that can achieve scale.

As illustrated in Box 107, some of these tools are under development or already in use and the challenge will be to make them more widely available.

Box 107

Management tools for microinsurance

A key strategy to strengthen the capacity of microinsurance managers is to ensure that they have access to, and know how to use, appropriate management tools. A number of recent tools have been developed that might enhance future performance, or inspire the development of future tools.

The HMI **health insurance software**, developed by the ILO-STEP, was designed to help the managers to record, verify and monitor enrolments, premium payments and claims. Through HMI, AssEF monitors 11 key indicators including enrolments, premium recovery, entitlement to benefits, frequency of utilization and average cost of services, as well as average expenses (claims and operating costs) per beneficiary. It also includes an accounting module to calculate annual technical results. The software allows managers to react quickly to anomalies.

The ILO-STEP programme has also developed a **feasibility study guide** for setting up health microinsurance schemes. It provides practical information for managers on everything from premium calculation to contracts with providers.

For its affiliated MFIs that work in partnership with insurance companies, Opportunity International has developed AIMS, **insurance software** that can be merged with OI's preferred banking software to eliminate duplicate record-keeping.

ICMIF has a **business-simulation tool**, Morotania, which explores the key issues in setting up and running a new insurance company. The simulation creates an enjoyable but challenging learning environment, which allows managers to sharpen decision-making and managements skills and learn first-hand about the reinsurance risks.

RIMANSI has developed an **actuarial modelling and business planning tool** for life, health and savings products which produces prospective income statements and balance sheets complete with actuarial reserves and expected claims. Managers use this tool to adjust the product pricing and benefits on an iterative basis until they can project a solvency ratio of 80 per cent by Year 4 and a targeted IRR of around 8 per cent.

Besides tools for managers, it is also necessary to strengthen support organizations and technical assistance providers, such as networks or federations of microinsurance schemes. If local TA providers and networks have the right tools and expertise, they can have a powerful multiplier effect.

Investment in developing actuarial expertise is also necessary. Miscalculations of risks and premiums can have drastic effects on microinsurance programmes as demonstrated by CARD's initial experience. Actuarial expertise can be secured either by employing in-house experts or, perhaps more realistically, outsourcing needs to consulting actuaries. Yet few actuaries understand the *micro* aspect of microinsurance. To achieve significant expansion and innovation, a new breed of actuary is needed which can use its spreadsheets to meet the needs of the poor in a sustainable manner.

2.2

Enhancing efficiency

One of the great imperatives for the expansion of microinsurance is to significantly reduce operating expenses relative to premiums. More efficient operations should result in lower premiums and/or additional benefits for policyholders – both would be welcome outcomes. More efficient operations might also mean that microinsurers could pay their employees better, resulting in improved staff retention and better customer service. Great expectations are placed on the potential of technology to enhance efficiency.

Nothing can make up for badly-managed companies. However, technology is a fundamental driver and has become a great equalizer. Throughout history, those that possessed more advanced technology dominated – politically,

militarily and economically. That was true during the industrial revolution and has not changed in the information age. What has changed is technological development's pace and accessibility. The microprocessor has enabled the masses to reap the fruits of automation. The birth of the Internet has provided connectivity to every corner of the globe, making information available to all.

Insurance is an information-processing business. The raw materials are customer data, product information, transaction details, investment records and so on. Even before the birth of the computer, large insurance companies drove the development of sorting, tabulating and calculating machines to improve efficiency. Today these capabilities are available to small insurers as well. Microinsurers big and small must take advantage of ways of improving efficiency if they are to be honest stewards of microinsurance premiums.

Implementing technology is a risky proposition and thus there is a natural reluctance by cost-conscious microinsurance practitioners to go down this route. The low start-up costs of manual processes are attractive; however, this approach does not establish a sustainable and scalable foundation for the massive expansion of microinsurance as it does not provide the ability to optimize processes and build economies of scale. An insurer unable to reach large numbers places itself in a precarious position.

In the developed world, major insurance companies invest on average 3 to 6 per cent of annual gross revenue in technology. The new technology architectures based on the Internet and wireless communications will prove to be a good growth catalyst for microinsurance. Similarly, using open-source software would be an inexpensive way for microinsurers and grassroots organizations to benefit from technology.

The key to success in this area is to align the technology solutions with business problems. Management information systems should be designed to support the business strategy, not the other way around. This link between technology and strategy is illustrated by the fact that several insurance companies, including TUW SKOK and La Equidad, have provided their delivery channels with software to help them sell and service microinsurance, and help the insurer manage its relationship with its distribution channels.

Technology applications are a critical success factor in enhancing the efficiency of the insurance business. Automation has been introduced in almost every operational area. As illustrated in Table 53, automation could play a significant part in improving the efficiency of microinsurance, not to mention enhancing customer service, strengthening management and training staff.

Table 53

Process automation transforms insurance operations

<i>Business process</i>	<i>Automation opportunity</i>
Policy issue and enrolment	<ul style="list-style-type: none"> – Agents can submit applications or enrolment requests via the Internet – Automated underwriting and policy issuance – Document printing and record retention via imaging – Automated risk-pooling better reflecting risk levels in premiums
Premium collections	<ul style="list-style-type: none"> – Automated billing for group clients – Premium posting and automatic lapse processing
Claims	<ul style="list-style-type: none"> – On-line claim submission – Tracking available on the Web – Fast claim processing and payment via local banks or ATMs – Effective records for processing and claims-experience studies
Actuarial studies and pricing	<ul style="list-style-type: none"> – Mortality and morbidity studies – Pricing analysis – Data sourcing and aggregation on a national level
Education and training	<ul style="list-style-type: none"> – Staff education and training via Internet-based services – Effective client-education techniques

Some microinsurers have already begun to automate. For example, Microcare (Uganda) and Opportunity Bank (Malawi) both issue smartcards to their policyholders. This enables them to easily verify that the premium is up to date and determine the level of coverage that the client has. In the absence of national identification systems, smartcards also confirm that the person trying to access benefits is actually covered under the policy.

VimoSEWA in India is testing a barcode system to manage client information. When clients subscribe, they receive barcode stickers. When they want to file a claim, illiterate clients stick a barcode onto a pre-addressed envelope and send it to the microinsurer. VimoSEWA's barcode scanner indicates which client needs assistance and the appropriate fieldworker is dispatched. Also in India, Tata-AIG is training its micro-agents to use an Internet portal to retrieve and submit customer account information, such as premiums due and collected.

Technology is not just the realm of the insurers; today, customers too want to benefit from its use in product delivery. Even the low-income market has increasing access to technology, such as cell phones and the Internet, which could be used to streamline operations. According to Prahalad (2003), "the proliferation of wireless devices among the poor is universal, from

Grameen Phone in Bangladesh to Telefonica in Brazil. Further, the availability of PCs in kiosks at a very low price per hour and the opportunity to videoconference using PCs are adding to the intensity of connectivity among those at the BOP (bottom of the pyramid).” Indeed, banking services are actively using technology to extend outreach to the poor (see Box 108). Insurance is likely to follow suit as long as the market education measures can be expanded to include the use of technology.

Box 108

Technological advances in banking services for the poor

Microfinance institutions have adopted a variety of technologies to supply services to the poor. Some of the most promising technologies might also be relevant for the expansion of microinsurance, including personal digital assistants (PDAs), smart cards and mobile-phone banking.

The use of **PDAs** by field staff provide advantages in the areas of transaction efficiency, error reduction and fraud prevention. In Bangladesh, the use of PDAs by SafeSave’s door-to-door collectors has eliminated three to four hours per day of data processing, and reduced the number of mistakes in recording transactions by 90 per cent compared to paper-based systems. The technology also made it possible to cut loan processing time in half (from two days to one), and increased adherence to product rules by preventing policy-violating transactions.

Similarly, **smart card technology**, such as that used by Prodem FFP in Bolivia, is expected to reduce the operating costs of serving rural areas. The cards have client identification information, including three fingerprint templates and financial data from Prodem’s MIS. With smart card and fingerprint readers at its 54 branches, Prodem FFP offers clients a quick means of conducting financial transactions. Prodem FFP has realized a number of benefits from implementing smart cards. Waiting lines for tellers have dropped dramatically since many cardholders who wanted to check their balances may now do so without assistance. The adoption of technology has given the MFI a competitive advantage and attracted depositors who appreciate the system’s speed and convenience.

Mobile-phone banking is another innovative product with great potential. To capitalize on this potential, Vodafone, with its local Kenyan affiliate, collaborated with a bank to provide services to clients of Faulu, a Kenyan MFI. This multilingual mobile-phone banking service allowed clients to transfer money, withdraw and deposit cash at registered local outlets and make loan repayments, all from their phones.

Source: Adapted from Churchill and Frankiewicz, 2006.

Technology cannot overcome every obstacle that microinsurance operations face. However, it can help optimize the return on investment and bridge operational gaps by enabling the communications and cooperation of stakeholders around the world. For example, a global data clearinghouse for actuarial studies, pricing and reinsurance could contribute significantly to expanded outreach, better products and the sustainability of providers.

2.3 Business model

The third challenge for microinsurance providers as they move forward is developing an effective business model. As illustrated in Part 4, all of the models currently in use have advantages and disadvantages. Obviously, one model will not be appropriate in all circumstances, and therefore the real challenge is to improve the existing approaches, exploiting their strengths and overcoming their shortcomings.

The criteria for success are business models that work for both the clients and other stakeholders, balancing short-term sustainability and long-term growth. Since the target market for microinsurance is relatively new, insurers need to adopt a market development approach whereby profitability is founded on volumes and long-term relationships.

Any insurance business model must acknowledge the need for reserves and reinsurance. Indeed, reinsurers are actively trying to identify a role for themselves in microinsurance. The reinsurer's role should focus on catastrophic risks, which are often excluded in microinsurance products. If catastrophic risks are excluded, insurance is not there to help people when they need it most; by covering these risks, reinsurance can play an important part in fortifying an emerging insurance culture.

A reinsurance-like approach could also help professionalize the activities of community-based and local microinsurance programmes. Although these schemes would still act as the first line of protection for their members, a local regulated insurer could "reinsure" these programmes. The regulated insurer could provide the financial back-up for certain risks and also technical input that may be lacking in community-based schemes. This would represent a new hybrid of the community-based and partner-agent models, while offering a greater variety of products to low-income members with greater professionalism.

The emergence of new models and delivery channels will be an important development for the future expansion of microinsurance. The distribution channel is the face of microinsurance for the customer, both for sales and servicing. The development of microinsurance depends largely on the quality and quantity of the delivery channels. The primary channel used today,

microfinance institutions, has limitations. While they certainly will have an ongoing role in extending insurance to the poor, to expand the outreach dramatically it will be necessary to engage new distribution channels. In particular, there is a need to organize the unorganized to offer group insurance. Involving social organizations, such as cooperatives, workers' associations and the like, in organizing the poor will greatly facilitate their access to insurance.

To involve new distribution channels in microinsurance, there will be a clear role for intermediaries, such as insurance brokers, which can serve as translators between grassroots distributors and corporate risk carriers. By understanding the priorities, needs and language of both parties, the intermediary can help improve the quality of the products and the relationship between the partners.

In the long term, the face of insurance will change and adapt to this market. Thanks to the massive expansion of Internet access, low-income people will be able to buy insurance on-line from insurers and their agents. Delivery channels will expand far beyond financial service providers like MFIs and will become omnipresent in retail shops, post offices, hospitals and doctors' surgeries – anywhere that a link can be made with risk-management needs. Even the products themselves will be transformed to respond more accurately to the direct needs of potential policyholders. Insurers will be able to offer such products because improved distribution will allow them to serve very large volumes of policyholders.

3

The regulatory landscape

The basis for providing risk-management services to the poor is a sound regulatory and corruption-free political foundation. Without this, it is impossible for microinsurance to develop in a sustainable way.

Insurance is and needs to be a highly regulated industry. Building a risk-management culture is difficult enough – it only takes one or two company failures to destroy it. Insurance supervisors are primarily responsible for consumer protection, which comes in two main forms: 1) protecting policyholders in general against insurance company failure and 2) protecting individual policyholders (or potential policyholders) against unscrupulous sales and unfair policy documents. As described in Chapter 5.2, there is also a third type of consumer protection – concern for the protection of those who cannot access insurance – which represents a market development function for insurance regulators. The extent to which regulators are willing and able to embrace this development function will have a significant influence on the future scope of microinsurance in their jurisdictions.

A significant share of the microinsurance market is currently covered by organizations outside the reach of supervisors. While it is not appropriate for supervisors to look the other way, the costs and benefits of supervising informal microinsurance need to be considered: is it better to have no access to insurance or to have access to unregulated insurance? Some countries have legal structures that take greater account of different types of ownership structures and regulatory requirements. For example, in the Philippines, CARD has created a mutual benefit association for its members. This MBA has professional management, reserves, limited products and markets, and a link to the regulatory system. Similarly in Senegal, health mutuals have been incorporated into the legal framework. Such regulatory flexibility will be necessary in the move to a massive expansion of microinsurance.

Efforts to offer alternative business structures for microinsurance are limited by the ability of the regulatory structures to manage the system and fulfil their consumer protection role. The reduced capital requirements advocated by some have significant potential for abuse. Generally, regulators use minimum capital requirements in two ways: (1) to ensure that an insurance company has sufficient capital to meet future obligations to policyholders and (2) to maintain efficiency in the insurance system to prevent it being overrun by inefficient operators that they cannot properly supervise.

The balance between prudence and entry barriers is a tenuous one. A hybrid approach linking informal schemes to regulated insurers may help to create a higher level of supervision in the system while opening up opportunities for greater microinsurance provision. In addition, self-regulated schemes of cooperative and mutual organizations need to be seriously considered as a means of extending insurance to the poor without overwhelming the insurance supervisors.

It is advantageous to have a certain level of consistency across regions and on a global basis for multinationals to enter this market, so that they can implement their processes on a global scale. Although regulations on a global or regional basis are a noble but improbable goal, it is realistic to envisage a certain level of collaboration among regulators that would eventually result in improvements and standards for all nations. Through the International Association of Insurance Supervisors (IAIS), for example, it may be possible to design and promote model microinsurance regulations. This association could act as a standard-setting body, recommending appropriate reserve levels, solvency limits, etc. for microinsurance.

Indeed, the expansion of microinsurance would receive a big boost if insurance authorities believed they had an active role to play in enhancing the inclusiveness of the insurance markets. How involved should regulators become in promoting microinsurance? Their approach will depend on

whether they see the low-income market as a threat to the financial stability of the insurance industry, or as a market opportunity that could potentially strengthen insurance companies. Some countries may follow India's approach and require commercial insurers to serve the low-income market, while others will explore less prescriptive means of making their insurance markets more inclusive. Either way, microinsurance promotion by regulatory authorities should help expand the product range and delivery channels insurers use to gain access to the poor, while opening up opportunities for alternative types of insurers.

Long the poor relation of the banking sector which has benefited from significant aid in the last ten years, the insurance sector in some countries is now beginning to receive some development assistance. This will result in much greater capacity at insurance regulators and will in turn allow for a greater variety of insurance provision models, but this will take time.

4 The environment for microinsurance

Many factors determine whether microinsurance can be made available, what products might be offered, how they will be offered, and the costs and benefits. The environment in which microinsurance operates is as important to consider as the policyholders, providers and regulations.

4.1 Healthcare quality

Health insurance has little value if there is no access to good-quality healthcare providers. Outside urban areas, such healthcare is often not available. Government and donor inputs have most frequently been invested in the cities, leaving the rural poor with low-quality medical practitioners and frequently no doctors. In some countries, the government healthcare systems advertise themselves as being free to all, yet the poor who need to access these facilities are quite aware of the value of the "gift" that must be provided even for the least assistance.

Governments and civil society must create healthcare systems guaranteeing quality, equality and transparency. The involvement of patients in the process of managing or governing local healthcare providers is one way to ensure that they are responsive to the needs of their market, which is a key advantage of the community-based health insurance schemes. If they are supported by a strong apex body, MHOs can open the systems to effective health insurance products, improve care of those in need and allow governments to focus more on the people who are truly destitute and can only be covered by social protection.

4.2 Data for risk management

The limitations of healthcare monitoring systems in the developing world also have a great impact on the ability of insurance companies to understand the risk of the low-income market, and thus to calculate premiums appropriately. Where they exist, morbidity and mortality data that filter into the national databases generally reflect the wealthier segments of the market because these are the people who can pay for healthcare and access systems that are able to record critical risk information accurately. The illnesses and deaths of the poor may not make it to the national databases, for example when they rely on informal medical care or return to their rural home to die. This leads to severe loadings on microinsurance products, or overly optimistic risk premiums – neither of which aids microinsurance outreach.

Better data will result from better healthcare, improved government record management and requirements by insurance regulators, many of whom review premium calculations prior to product approval. This will improve the foundation upon which risk calculations are made.

A particular data-management challenge in some developing countries is the fact that there is no national identification system. This dramatically increases the potential for insurance fraud – a dead person mis-identified as a policyholder, a hospital patient being covered under someone else's policy, and numerous other ways in which the non-insured might be covered as an insured. The significant cost of such fraud is reflected in premiums. This problem is not limited to insurance and as countries move towards introducing reliable national identification systems, the financial sector in general will improve.

4.3 Macroeconomic conditions and the development of financial markets

Weak economies with periodic bouts of hyperinflation and currency devaluation create strong deterrents to long-term investment and thus undermine the life insurance business. Weak banking infrastructures make it difficult to manage financial assets efficiently. Effective and diverse microinsurance depends on strong economies with efficient financial markets and infrastructures. Well-conceived efforts in this area by governments will have a positive impact on the expansion of insurance products.

One aspect of microinsurance that is often overlooked is the potential for microinsurers to accumulate large amounts of capital and reserves. The accumulation of any investment capital is highly desirable in the developing world. However, unlike other industries, insurers tend to build long-term capital, which fosters the growth of long-term investment markets, creating

an ideal situation for the development of physical infrastructure. Most insurance companies have investment strategies based on an asset-liability matching model and since the liabilities can fall due in 15 or 30 years, the appropriate investment opportunities are usually found in government bonds, transportation projects and housing construction. It is not a total coincidence that countries where the insurance and pension sectors are fully developed also have vibrant long-term investment markets and a substantial physical infrastructure.

4.4 Catastrophic risks

The catastrophic risks of climate change, HIV/AIDS, avian influenza and others still to come will have an important and dramatic impact on the provision of all insurance, and especially on microinsurance. Low-income people are typically the front-line losers in catastrophic events. Since their incomes are low, they live in high-risk areas where others will not live. They must take risks that make them more susceptible to diseases, and have less ability to cope when catastrophes do occur. Insurers and reinsurers need to recognize the effect of catastrophic risks on the low-income market and work to develop efficient mechanisms to help the poor prepare for these risks and recover after they occur.

Due to a lack of care for the environment across the globe, weather is becoming more unpredictable. The resulting natural disasters hit agricultural communities the hardest. Governments and the insurance industry are hard-pressed to protect against these losses; notwithstanding that, only 20 per cent of worldwide agricultural production – crop and livestock – is insured today (Kasten, 2004). An innovative approach to extending financial protection to small farmers, herders and producers is index-based insurance. Simply put, it moves away from individual farm insurance towards coverage for a farming area. This would make collective care for the environment in the insured community relevant and essential to help mitigate losses.

The health issues of HIV/AIDS, new mutated flu strains, malnutrition and other diseases will be exacerbated in the future. Although microinsurance cannot solve these issues single-handedly, it can be a valuable tool in the battle against these scourges if microinsurance prepares and adapts. For example, the role of insurers in building appropriate infrastructure such as preventive healthcare will become more prominent as appropriate risk-management products are offered in these markets.

5 Embracing the future

If the future were known with absolute certainty, futurists would be redundant. They consider historical and current developments and expectations of the future to identify emerging trends. Actuaries are the futurists of insurance – they look at past experience and forecast the future using mathematical and statistical models of mortality and morbidity. Among the authors and readers of this book's chapters are consulting actuaries who have been advising microinsurance practitioners. What future do they see for microinsurance as they gaze into their crystal ball?

- Expanded technology where even low-income people have easy access to insurance products through computers, cell phones and smartcards. For insurers this will dramatically improve access to the market.
- Improved awareness of the benefits of insurance within the low-income market. People will appreciate the usefulness of insurance and their greater expectations will make for a more discerning market.
- A better distinction between what government social protection systems will do and what other insurance mechanisms will cover. This will help to clarify which risk-management solutions will be appropriate for which sections of the population.
- The spectre of global climate change, emerging diseases and other potential catastrophic events will hang over all long-term plans.

In the short run, in some countries, microinsurance, though desperately needed, will not spread massively; nor will it offer the variety of products and services that could help low-income people. These countries are simply not moving towards an environment which would allow successful microinsurance markets. Where conditions are improving – with stable economies, the development of financial markets, improving healthcare quality, insurance supervisors with a market development agenda, etc. – microinsurance will flourish. Such a change is likely to take time without a concerted push by policymakers, donors and the international community. Indeed, improved risk protection for the poor is not just a local issue, as epidemics and disasters can have ripple effects across the globe, justifying a greater role for international agencies and multinational corporations.

To insure the poor, customers, regulators, policymakers, insurers and social organizations must work together with a common purpose and unrelenting spirit:

- **Insurers** must strive to understand the customer’s changing needs and adapt their products and services accordingly, continually improving the cost-benefit ratio for clients.
- **Regulators** must promote a development agenda for inclusive insurance markets, finding the right balance between protecting consumers and expanding access.
- **Policymakers** need to create an enabling environment that includes the necessary infrastructure for providing microinsurance.
- **Social organizations**, including employers’ and workers’ organizations, cooperatives, NGOs and other associations can play a critical role in organizing workers in the informal economy who lack access to social protection or other types of microinsurance.
- Lastly, the **billions of poor people** who do not have a formal way of coping with risk must respond positively to the efforts of providers and regulators in accepting a culture of insurance and its capability to provide financial freedom, security and well-being.

By itself, microinsurance will not put a major dent in poverty. However, if risk protection is effectively coupled with efforts to enhance productivity, together they can make great strides towards alleviating poverty and achieving the MDGs. Microinsurance will have succeeded when it is no longer needed. As the former Chair of Delta Life, Monzurur Rahman, said, “We want to see the day when there is no more microinsurance, just insurance.”

Appendix 1

Description of microinsurance providers

Activists for Social Alternatives (ASA)

Microinsurance and microfinance institutions: Evidence from India

James Roth, Craig Churchill, Gabriele Ramm and Namerta, September 2005, Case Study No. 15

Founded in 1986, ASA operates in the Indian state of Tamil Nadu, providing microcredit and a variety of non-financial services to its clients. Purchase of insurance is closely linked to borrowing from the organization, which disbursed around 55,000 loans in 2004. Although it has experimented with self-insurance, ASA now works with private insurance companies that bear all the risk of its life insurance product. It is also licensed to act as an agent of an insurance company to sell different products, but has maintained its focus on servicing the needs of low-income groups. Seven employees are involved in its insurance operations full-time.

AIG Uganda

AIG Uganda: A member of the American International Group of companies

Michael J. McCord, Felipe Botero and Janet S. McCord, April 2005, Case Study No. 9

AIG Uganda, a private for-profit insurance company, is part of one of the largest insurance groups in the world. It launched its first microinsurance product in 1997 in Uganda after being approached by FINCA Uganda, an MFI. It has since expanded its microinsurance operations to 26 MFIs, including one in Tanzania and one in Malawi. It offers a group personal accident product with disability, accidental death and credit life benefits. In 2003, AIG Uganda covered 1.6 million persons – borrowers of the MFIs and their family members. The company uses a partner-agent model for its microinsurance operations and all but one of the MFIs make insurance mandatory for their borrowers.

All Lanka Mutual Insurance Organization (ALMAO)*ALMAO and YASIRU, Sri Lanka*

Sven Enarsson and Kjell Wirén, October 2005, Case Study No. 22

All Lanka Mutual Insurance Organization (ALMAO) was licensed as a life insurance company in 2002. In 2005, ALMAO was also given a licence to provide general insurance products. The company currently offers long-term, life, accident and loan protection microinsurance products. The company is linked to the Sanasa movement, a network of credit and savings associations across Sri Lanka. ALMAO's predecessor was set up in 1991 to provide poor people with coverage for a range of risks. Since its registration as an insurance company, ALMAO's product portfolio has changed significantly and its older products are in the process of being phased out. These older products also included disability, hospitalization, death and life savings insurance covering 47,000 persons. Its new endowment products have not yet been very successful.

Association d'Entraide des Femmes (AssEF)*AssEF, Benin*

Olivier Louis dit Guérin, December 2005, Case Study No. 20

The Association d'Entraide des Femmes (AssEF), a microfinance cooperative, was created in 1999 to serve low-income women in the deprived areas of the capital and its surrounding areas. AssEF consists of some 130 savings and credit associations and funds. Its health insurance product had 2,300 beneficiaries at the end of 2004. Most of AssEF's clients are active in produce sales, catering, trading of staple items, sales of fabric and jewellery, and handicrafts. Its voluntary health microinsurance product is only for members and has both inpatient and outpatient benefits. The services can be accessed at contracted healthcare providers and there is a co-payment for all services. The insurance is provided in-house with technical support from the ILO-STEP programme.

Bangladesh Rural Advancement Committee (BRAC)*Health microinsurance: A comparative study of three examples in Bangladesh*

Mosleh U Ahmed, Syed Khairul Islam, Md. Abul Quashem and Nabil Ahmed, September 2005, Case Study No. 13

BRAC has offered health insurance to the rural poor since 2001, when it started the Micro Health Insurance for Poor Rural Women in Bangladesh (MHIB) project. The scheme operates in 98 sub-districts and had a member-

ship of over 12,000 families in 2004. It offers three insurance products: an annual general package, a package targeted at pregnant women and a product targeted at school children. Healthcare is primarily provided through the parent NGO's network of community health workers, health paramedics and clinical facilities, but there are referrals to other providers when cases are beyond the capacity of the network. Policyholders must make co-payments, but the "ultra-poor" are exempt from paying the premium for the general package.

Bienestar Magisterial (BM)

Health microinsurance: A comparison of four publicly-run schemes, Latin America

Jens Holst, November 2005, Case Study No. 18

Bienestar Magisterial is a mandatory health insurance scheme in El Salvador for full-time teachers on the payroll of the Ministry of Education and their families. Created in 1969, it covered around 75,000 persons by 2003. The benefit package includes primary healthcare, specialized outpatient care, inpatient care through referral and emergency care. Healthcare is provided primarily through around 100 family doctors who guide members through the system if more specialized care is needed. Physicians and facilities are contracted by the programme to provide care. Provider compensation is based on a variety of different systems such as a fee-for-diagnosis-related-group and fee-per-diem. Financing of the scheme is from direct income contributions. There are no co-payments.

CARD Mutual Benefit Association (MBA)

CARD MBA, the Philippines

Michael J. McCord and Grzegorz Buczkowski, December 2004, Case Study No. 4

CARD MBA is an insurance institution that started its operations in 1999. It operates in three regions of the country and offers life insurance and integrated credit life and disability insurance, along with a provident fund for long-term savings that does not have a risk-pooling element. In 2003, around 580,000 lives were insured in the scheme. CARD MBA is one of three sister organizations the aim of which is to improve the quality of life of poor women, particularly those residing in rural areas. It provides insurance for people borrowing from the CARD Bank, for whom cover is compulsory. Sales delivery, premium collection and claims payments are outsourced to the sister organizations for a fee.

Christian Enterprise Trust Zambia (CETZAM)¹*Technical assistance for the promotion of microinsurance: The experience of Opportunity International*

Richard Leftley, June 2005, Case Study No. 11

CETZAM is a microfinance NGO founded in 1995 to fight poverty through microenterprise development. It initially offered a credit life product and now also offers funeral and property insurance as well. There were around 5,000 subscribers to its microinsurance products in 2004. CETZAM acts as an agent of a private sector insurance company. The credit life and funeral insurance products are compulsory for people borrowing from the organization.

Columna*Columna, Guatemala*

Carlos Herrera and Bernardo Miranda, December 2004, Case Study No. 5

Columna, an insurance company created in Guatemala in 1993, operates primarily through the country's credit unions and cooperatives to serve the self-employed in the informal economy. Its predecessor was the Guatemalan National Federation of Credits Unions' life insurance scheme, which had started in 1970. The majority of Columna's clients are from its affiliated credit unions and cooperatives, but some clients join individually or through partner NGOs. Though Columna had over 500,000 clients in 2003, and offers a range of products from motor insurance to insurance against assault, only some products can be considered microinsurance. These are: credit life and life savings plans which are mandatory for people borrowing from any of Columna's partner credit unions/cooperatives, and a voluntary life insurance product that offers benefits in the event of death or disability.

Coordination régionale de mutuelles de santé de Thiès (CRMST)*Mutual health insurance, CRMST, Senegal*

Klaus Fischer, Ibrahima Hathie, Issa Sissouma, September 2006, Case Study No. 24

Coordination de Thiès is an association of 39 mutual health organizations, with about 75,000 beneficiaries at the end of 2005 (up from about 70,000 the previous year), covering all pathologies offered to individuals in public health institutions. In the late 1980s, Thiès was the birthplace of the now rapidly growing movement of MHOs in West Africa that now includes

¹ CETZAM is also discussed in *Madison Insurance, Zambia*, Case Study Nor. 10 by Lemmy Manje.

hundreds of schemes. The MHOs are independent risk-carrying entities, with the majority based on rural areas. The Coordination plays an important role in providing support to the MHOs, acting as intermediary between MHOs and other stakeholders, helping with the development of new MHOs and contracting health service providers. It falls under the law of associations that recognizes the form of “*union régionale*”, which corresponds to Coordination’s structure.

Delta Life

Delta Life, Bangladesh

Michael J. McCord and Craig Churchill, February 2005, Case Study No. 7

Delta Life is an insurance company founded in 1986. It started offering insurance products for high- and middle-income groups and then, taking inspiration from the Grameen Bank, it launched a voluntary microinsurance product targeted at low-income persons in the informal economy in 1988. It currently offers a range of endowment products, and had 859,000 low-income policyholders in 2002. The products offered are perceived by clients and staff more as long-term savings products than insurance. Certain occupational groups are excluded from purchase of certain products and most of its microinsurance clients live in rural areas.

La Equidad Seguros

La Equidad Seguros, Colombia

Gloria Almeyda and Francisco de Paula Jaramillo, September 2005, Case Study No. 12

La Equidad Seguros, established in Colombia in 1970, offers a variety of insurance products both for institutional and individual needs; it also targets low-income groups. It has partnered and is primarily owned by cooperatives throughout the country. Among its many products, two group products can be considered microinsurance. Both of these cover death and disability and are distributed through La Equidad Seguros’ partner organizations. One of these products is only available to clients of a microfinance institution, Women’s World Foundation (WWF). WWF acts as an agent, responsible for marketing, premium collection and claims processing. The other product is a similar one targeting La Equidad’s partner cooperatives. There were around 30,000 microinsurance policyholders in 2004, most of whom either own informal microenterprises or are low-wage workers.

FINCA Uganda

AIG Uganda: A member of the American International Group of companies

Michael J. McCord, Felipe Botero and Janet S. McCord, April 2005, Case Study No. 9

The attention surrounding the initial partnership between FINCA Uganda, formerly a microfinance NGO (now a regulated financial institution), and AIG Uganda served to launch the partner-agent model as an effective and potentially profitable way to deliver insurance to the low-income market. Although in 2003, 26 MFIs had group policies with AIG Uganda covering 1.6 lives, FINCA was the initial driver of the product design and enhancements.

Grameen Kalyan (GK)

Health microinsurance: A comparative study of three examples in Bangladesh

Mosleh U Ahmed, Syed Khairul Islam, Md. Abul Quashem and Nabil Ahmed, September 2005, Case Study No. 13

Grameen Kalyan's health insurance scheme was started in 1996. Around 58,000 families, the majority of whom were members of the Grameen Bank, purchased insurance in 2004. The scheme offers an annual product covering preventative and curative health services. Healthcare is provided through the programme's 28 clinics and community health workers in eight districts. Each clinic has a staff of around 10 employees. There are co-payments for all services except for preventative, family-planning and health education services, which are provided through community health workers.

International Cooperative and Mutual Insurance Federation (ICMIF)

Lessons learnt the hard way

International Cooperative and Mutual Insurance Federation (ICMIF), January 2005, Case Study No. 6

ICMIF is an international association of insurers operating on the principles of the cooperative movement and democratic mutuality. Founded in 1922, it now has 141 members in 67 countries, comprising more than 300 insurance companies. The principal member services provided by ICMIF are reinsurance, development, market intelligence, investment, the biennial global conference and training. This case study considers the experiences of nine unnamed members (or former members) that experienced serious problems over the years. By analysing their experiences, the study creates a framework for an insurer's vulnerabilities. Although the companies cannot strictly

speaking be called microinsurers, the lessons they learned are applicable to the extension of insurance to low-income markets.

Karuna Trust

Karuna Trust, Karnataka, India

Ralf Radermacher, Olga van Putten-Rademaker, Verena Müller, Natasha Wig and David Dror, November 2005, Case Study No. 19

Founded in 1987, Karuna Trust is a multipurpose NGO dedicated to rural development and rural health in the Indian state of Karnataka. It launched a health insurance pilot programme in 2002 to complement the public health system. Its integrated health insurance product offers benefits for transportation to a health facility, inpatient drugs and income during hospitalisation and post-surgery recovery. More than 61,000 persons were covered in 2004, although the organization experienced a significant drop the following year. The premium for the product was initially completely subsidized (by UNDP), but many of the clients were less inclined to purchase the insurance when they actually had to pay for it. The product is offered in partnership with a state-owned insurance company.

Madison Insurance

Madison Insurance, Zambia

Lemmy Manje, May 2005, Case Study No. 10

Madison Insurance started offering microinsurance products in 2000 in partnership with microfinance institutions. In 2003, there were over 30,000 subscribers to its group credit life and group funeral insurance products. The purchase of insurance policies is mandatory for people who borrow from these partner financial institutions.

MAFUCECTO

MAFUCECTO, Togo

Catherine Tremblay, Marisol Quirion, Suzanne Langlois and Frank Klutsé, October 2006, Case Study No. 25

Although initially set up in 1989 by the credit union network (FUCEC) to provide personalized life insurance products through the cooperatives in the network, MAFUCECTO initially encountered problems because the credit unions found the cover too expensive. In 2003, a desire to improve services and partner satisfaction led the network to completely reorganize MAFUCECTO and introduce new procedures and products, with funding

and technical assistance from international entities. The project goal was to set up an insurance company for the sub-region to provide common insurance products for the six credit union networks. For the moment, however, only loan-linked life insurance is offered through one network.

Malawi Union of Savings and Credit Cooperatives (MUSCCO)

MUSCCO, Malawi Union of Savings and Credit Cooperatives

Sven Enarsson and Kjell Wirén, March 2005, Case Study No. 8

Founded in 1980, MUSCCO is a federation that serves the needs of its member savings and credit cooperatives. At its peak in 2000, MUSCCO worked with 111 cooperatives with 66,000 members. It offers credit life and life savings microinsurance products and had 56,000 insureds in 2003. MUSCCO's credit unions target low-income groups, small farmers and government employees. Its products are exclusively for its cooperative partners' members and are also compulsory for them. Some of the insurance operations are carried out by the partner cooperatives but risks are managed in-house by the federation.

Opportunity International (OI)

Technical assistance for the promotion of microinsurance: The experience of Opportunity International

Richard Leftley, June 2005, Case Study No. 11

Opportunity International, an international NGO created in 1971, serves over 800,000 borrowers worldwide. Its mission is to provide opportunities for people in chronic poverty to transform their lives through creating jobs, encouraging small business and strengthening communities. It works with banks and MFI NGOs in 30 countries. As a result of demand from clients, the organization has provided technical assistance since 2002 to develop microinsurance products. While OI commenced its microinsurance activities in Africa, it has now spread to other parts of the world. In 2005, Opportunity's partners covered approximately 2,700,000 low-income persons. Recently, it established the "Micro Insurance Agency" as an insurance broker serving the poor.

Pulse Holdings Ltd.*Madison Insurance, Zambia*

Lemmy Manje, May 2005, Case Study No. 10

Pulse is an MFI that began in 1995 with support from CARE International to address urban poverty by providing microcredit. In 2001, it was incorporated as an independent organization, Pulse Holdings Limited. It offers two types of business loans and two emergency products. It is located in the capital and had around 2,000 clients in 2004. It offers microinsurance in partnership with Madison Insurance, but instead of earning a commission, Pulse has a profit-sharing arrangement with the insurer.

Seguro Basico de Salud (SBS)*Health microinsurance: A comparison of four publicly-run schemes, Latin America*

Jens Holst, November 2005, Case Study No. 18

The Seguro Basico de Salud was a public health insurance scheme in Bolivia created in 1999. It targeted the urban and non-urban poor and the benefit package was for pregnant women, children under five years of age and people affected by some communicable diseases. Health services were provided primarily through public health facilities. Funding of the programme was tax-based with supplements for certain programmes, and there were no co-payments for users. Health providers were paid by municipal governments according to a fee-for-service remuneration schedule. In 2003, the Seguro Basico de Salud merged into the Seguro Universal Materno Infantil.

Seguro Integral (SI)*Health microinsurance: A comparison of four publicly-run schemes, Latin America*

Jens Holst, November 2005, Case Study No. 18

The Seguro Integral is a public health insurance scheme in Paraguay that was started in 2002. Coverage will eventually be extended to all regions and population groups, but the target group for the pilot project are women of child-bearing age and children under the age of five in the region of Caazapá. Since 2004, beneficiaries have obtained healthcare at primary providers within the public health system. There is a referral system to access secondary and tertiary level care. Funding for the programme is supposed to come from the health ministry, the district government and the municipal government, as well as from enrollees' monthly contributions. There are no co-payments.

Seguro Materno-Infantil (SMI)

Health microinsurance: A comparison of four publicly-run schemes, Latin America

Jens Holst, November 2005, Case Study No. 18

The Seguro Materno-Infantil, created in 1998, was a public health insurance scheme in Peru targeting the health needs of pregnant women, new mothers and children under the age of five years. It merged into the Seguro Integral de Salud in 2001, which serves a broader public. The Seguro Materno-Infantil was designed to fight against some of the most important causes of mortality. At its peak in 2001, the programme covered 22 health districts and there were around 350,000 beneficiaries. Healthcare services were provided by public providers (ranging from health centres to hospitals), where members were enrolled. Financing of the programme was primarily tax-based. However, at the time of enrolment, members had to pay a fee, though it was waived for a significant proportion of members. Provider payment was on a fee-for-service system with limitations on the frequency of use. There were no co-payments.

ServiPerú

ServiPerú, Perú

Máximo U. Rodríguez and Bernardo Miranda, January 2004, Case Study No. 1

As a result of changes in regulations and in the market in the early 1990s, cooperative insurer SEGUROSCOOP could no longer keep its licence. Instead, in 1994, it recreated itself as ServiPerú, an insurance broker and service provider that serves as a link between cooperatives and insurance companies. It offers an integrated health and funeral insurance product and had around 94,000 beneficiaries in 2003. There are co-payments on all covered health benefits. In addition to the integrated microinsurance product, ServiPerú offers motor insurance, life savings and credit life insurance services.

Shepherd

Microinsurance and microfinance institutions: Evidence from India

James Roth, Craig Churchill, Gabriele Ramm and Namerta, September 2005, Case Study No. 15

Shepherd, an Indian NGO, was created in 1995 and operates in state of Tamil Nadu. It is a network of self-help groups and acts as facilitator or intermediary between the groups and formal institutions (such as banks). It offered three life insurance products as well as livestock, accidental death, asset and

health insurance products and had around 15,000 beneficiaries in 2004. Following a partner-agent model, Shepherd is linked to two state insurance companies, which bear all the risk of the products.

Society for Social Services (SSS)

Health microinsurance: A comparative study of three examples in Bangladesh

Mosleh U Ahmed, Syed Khairul Islam, Md. Abul Quashem and Nabil Ahmed, September 2005, Case Study No. 13

Society for Social Services is a multipurpose NGO that provides microcredit and a range of social services. Its health insurance scheme, started in 1996, serves six sub-districts and had a membership of around 27,000 families in 2004. It offers an annual insurance product for curative health services. Enrolment in the scheme is compulsory for people borrowing from the NGO. Healthcare is provided by SSS through one urban hospital, 16 rural clinics and health workers. There are co-payments on certain services but full subsidies are possible for the “ultra-poor”. Services are provided through community health workers, traditional birth attendants and qualified medical professionals who are based in the urban hospital but who travel to the clinics periodically.

Spandana

Microinsurance and microfinance institutions: Evidence from India

James Roth, Craig Churchill, Gabriele Ramm and Namerta, September 2005, Case Study No. 15

Spandana is an Indian NGO formed in 1992. It operates in the municipality of Guntur, among other places, and offers microcredit, initially following the Grameen model but later developing its credit provision model. It first offered microinsurance products in 1998. In 1994, it offered an integrated insurance product covering credit life, spouse’s death, and limited asset loss. Death and destruction caused by epidemics and natural disasters were excluded from coverage. The product was compulsory for people who borrowed from Spandana and had around 390,000 policyholders in 2004. Its self-insurance scheme was not regulated.

Tao Yeu May's Mutual Assistance Fund (TYM)*TYM's Mutual Assistance Fund, Viet Nam*

Nhu-An Tran and Tan See Yun, June 2004, Case Study No. 3

Tao Yeu May's Mutual Assistance Fund is a Grameen replication project that was launched in 1993 by Vietnamese Women's Union. It works primarily in the northern provinces. Its core business is microcredit for women and it has offered an integrated credit life, health, disability and funeral product since 1996. Around 68,000 people (borrowers and spouses) were insured with TYM in 2004. TYM's microinsurance programme, operating on a self-insurance basis, aims to provide financial support in times of crisis; however, it is not intended to cover all the expenses associated with the crisis.

Tata-AIG Life Insurance Company*TATA-AIG Life Insurance Company Ltd., India*

James Roth and Vijay Athreye, September 2005, Case Study No. 14

Tata-AIG is a private-for-profit life insurance company, organized as a joint venture between a large Indian conglomerate and the American International Group. The company started microinsurance operations in 2001 to comply with Indian insurance regulations, and now offers three voluntary life insurance and savings products through partner NGOs and micro-agents. There were over 13,000 microinsurance policyholders in 2005. Tata-AIG has collaborated with over 50 NGOs and most of the selling and servicing is done through them, either directly or indirectly. In its micro-agent model, Tata-AIG obtains recommendations from NGOs on members of the community who could be good agents for microinsurance policies (micro-agents). The NGO then assists the agents with training and administrative support. The products for rural low-income persons are voluntary.

Taytay Sa Kauswagan (TSKI)*Technical assistance for the promotion of microinsurance: The experience of Opportunity International*

Richard Leftley, June 2005, Case Study No. 11

Taytay Sa Kauswagan is a microfinance NGO founded in 1986. The organization currently offers a compulsory life and credit life insurance for all borrowers on behalf of a local insurance company. Around 900,000 persons were covered in 2005.

TUW SKOK*TUW SKOK, Poland*

Craig Churchill and Terry Pepler, May 2004, Case Study No. 2

TUW SKOK is the primary insurance provider of credit unions in Poland. Its predecessor was created in 1993 and TUW SKOK started operations in 1998. It offers a property product, a savings completion product, and three accidental death and disability products that can be considered microinsurance. It had around 93,000 low-income policyholders and a total membership of around 925,000 in 2003. All TUW SKOK's microinsurance products are sold as group insurance. The organization outsources many activities such as actuarial services and sales, which are done through credit unions. Additionally, the organization also offers a range of insurance products for credit unions themselves, including deposit insurance.

Union des Mutuelles de Santé de Guinée Forestière (UMSGF)*L'Union des Mutuelles de Santé de Guinée Forestière, Guinea*

Bruno Gautier, Allan Boutbien and Bruno Galland, October 2005, Case Study No. 17

The Union des Mutuelles de Santé de Guinée Forestière is a network of mutual health organizations. Established in 1999, the network provides representation for the MHOs in dealings with their various partners. The MHOs offer health insurance products covering around 14,000 persons in 2005. The product is aimed at low-income groups in both rural and urban settings. The insurance offered by the MHOs tends to cover cost of transport to hospitals, inpatient care and even outpatient care in some packages. Covered health services are provided only at public health facilities.

Union Technique de la Mutualité Malienne (UTM)*L'Union Technique de la Mutualité Malienne, Mali*

Klaus Fischer, Issa Sissouma, Ibrahima Hathie, August 2006, Case Study No. 23

The Union Technique de la Mutualité Malienne (UTM), an apex body of MHOs, was created in 1998 with support from Mutualité Française. Thirty-two MHOs are affiliated to the UTM, covering approximately 40,000 persons. The insurance benefit typically covers between 60 and 75 per cent of the user fees required to gain access to services offered in public health institutions. In addition, UTM has also designed a standard health microinsurance product that it administers. The MHOs have the option of offering either the standard health insurance product or more tailored products. Each

MHO is a legally recognized as a *mutual*, a separate institution owned by its members. MHOs are the primary insurance providers and risk carriers. The UTM is registered as a second-tier mutual institution, owned by the primary level member MHOs. The UTM provides support to the MHOs, acting as intermediary between MHOs and other stakeholders, helping with the development of new MHOs, contracting health service providers and developing new products. The UTM also has a certain supervisory function over the operations of the individual MHOs.

Vimo Self-Employed Women's Association (Vimo SEWA)

VimoSEWA, India

Denis Garand, October 2005, Case Study No. 16

The Self-Employed Women's Association is an Indian trade union for self-employed women founded in 1972 in the state of Gujarat. It set up a special department for insurance in 1992, VimoSEWA, which acts as an insurance broker. VimoSEWA offers a voluntary product with life, health and asset benefits covering more than 110,000 persons in 2004. The insurance product offered by VimoSEWA has undergone many changes and is now offered in partnership with two private-sector insurance companies.

Yeshasvini Trust

Yeshasvini Trust, Karnataka, India

Ralf Radermacher, Natasha Wig, Olga van Putten-Rademaker, Verena Müller and David Dror, November 2005, Case Study No. 20

Yeshasvini Co-operative Farmers Health Care Trust is a charitable trust in Karnataka. Yeshasvini's microinsurance activities were initiated in 2002 in cooperation with state authorities and cooperatives. The trust offers health insurance, covering approximately 1.45 million persons in 2004. The benefits are primarily limited to surgery, but also include outpatient care and tests in certain circumstances. The benefits, which are provided cashless to the clients, can only be accessed at certified partner hospitals. The trust outsources certain activities to third-party administrators, but manages the risk in-house. Distribution of the product is done through local cooperatives.

Yasiru Mutual Provident Fund (Yasiru)*ALMAO and YASIRU, Sri Lanka*

Sven Enarsson and Kjell Wirén, October 2005, Case Study No. 22

The Yasiru Mutual Provident Fund (Yasiru) is a microinsurance provider in Sri Lanka and was registered as a special society in 2000. Yasiru was initially linked to the ACCDC, a network of community-based organizations in seven districts, but the microinsurer has now entered into partnerships with several other NGOs. Yasiru offers an integrated accident, disability, life and hospitalization microinsurance product covering around 24,000 persons in 2004. The microinsurance product is targeted at the whole family, which can choose from five different levels of coverage.

Appendix 11

About the authors

Mosleh Uddin Ahmed is a UK-qualified chartered accountant and an independent consultant on microinsurance and migrants' remittances. Mosleh has over 15 years' experience in microfinance in Bangladesh, India, Pakistan, Nepal and Sri Lanka. He worked with Gono-Grameen Bima of Delta Life Insurance in Bangladesh as Deputy Managing Director and as the financial controller for the Rural Employment Sector Programme (RESP) in Bangladesh, a poverty alleviation programme funded by SIDA. He is at present CEO of Microinsurance Research Centre – a “not-for-profit” organization based in the UK and Bangladesh. He is a member of the UK All Party Parliamentary Group on Microfinance, London Microfinance Club and PlanetFinance UK.

Gloria Almeyda started her international credit union (CU) career with CUNA Mutual as an intern from EAFIT University in her native country, Colombia. Later, she joined WOCCU's international technical operations and worked in Latin America, Asia and Africa. Upon her return to Colombia, she became Executive Director of EDUCONAL – the Technical Corporation of the Colombian national CU federation. She also led the microenterprise programme of Fundación para el Desarrollo Integral, and collaborated with other institutions in microenterprise-related policy, promotion and development. She is currently a Regional Coordinator for Central America/Caribbean and Mexico, at the Center for Inter-Cultural Education and Development (CIED) of Georgetown University.

Felipe Botero has worked in the insurance industry for over 20 years. As an information technology specialist, Felipe has seen the evolution of technology from the days of overnight batch-processing and mainframe computers, to today's Internet-based world of straight-through processing and customer self-service. Throughout his career with MetLife, headquartered in New York City, Felipe has supported life, health, disability and annuity systems. While attending the MBA in Finance programme at New York University, Felipe became interested in microfinance and has dedicated himself to developing a microinsurance practice within MetLife.

Grzegorz Buczkowski is president of T UW SKOK, a mutual property and casualty insurance company (since 1997), and TU SKOK Życie SA, a life insurance company of the Polish credit union system (since 2003). He has 16 years' experience with Polish credit unions, starting as Foreign Relations Officer with Foundation for Polish Credit Unions. He spent five years as managing director at TU SKOK Benefit SA, a joint insurance operation of CUNA Mutual Group and Foundation for Polish Credit Unions. Mr Buczkowski holds a MA in English Literature from Gdansk University, Poland and an MBA from Gdansk University and Strathclyde University, Glasgow, Scotland. In 2001, he received one of the first WOCCU Young Credit Union Professional Awards.

Doubell Chamberlain heads the Access to Financial Services Practice at Genesis Analytics and holds a Masters in Economics (cum laude) from the University of Stellenbosch. Over the last five years, he has worked on numerous projects relating to developing strategies to extend financial services (including insurance) to the poor in southern Africa and the review and assessment of regulatory impacts on various components of the financial and non-financial sectors. He is currently leading a multi-country study on the impact of Anti Money Laundering/Combating the Financing of Ter-

rorism (AML/CFT) regulations on access to financial services in developing countries as well as an IDRC study on developing the principles for regulating microinsurance.

Arup Chatterjee is Deputy Director, Insurance Regulatory And Development Authority of India and currently on deputation as an Advisor to the International Association of Insurance Supervisors (IAIS), Switzerland. Besides an honours degree in economics, he possesses a master's in international economics and a master's in international business. His experience includes a rare blend of hardcore insurance business operations with expertise in insurance regulation and supervision. This combination has helped him gain a deep insight into development and regulation of insurance in emerging markets.

Craig Churchill joined the ILO's Social Finance Programme in 2001. Craig has microfinance experience in both developed and developing countries having previously worked for Get Ahead Foundation in South Africa, ACCION International, the MicroFinance Network and Calmeadow. In his current position, he focuses primarily on the role of financial services that the poor can use to manage risks and reduce their vulnerability, including microinsurance. He serves as Chair of the CGAP Working Group on Microinsurance and on the editorial boards of the *MicroBanking Bulletin* and the *Journal of Microfinance*. Craig has authored and edited dozens of articles, papers and monographs on various microfinance topics including microinsurance, customer loyalty, organizational development and management, governance, lending methodologies, and regulation and supervision.

Monique Cohen is President of Microfinance Opportunities, a non-profit organization founded in 2002. She is a recognized expert on the poor's use of financial services and client assessment, including market research and impact assessment in microfinance. Dr. Cohen has pioneered the introduction of financial education for poor people in developing countries. She designed and led the AIMS project at USAID in Washington, where she served as Senior Technical Advisor in the Office of Microenterprise Development, 1994–2002. She is co-author with Jennefer Sebstad of "Microfinance, risk management and poverty", and "Reducing vulnerability: The demand for microinsurance". Dr. Cohen has published extensively on microfinance and has taught at the Boulder Microfinance Training Program. Monique Cohen has a PhD from Clark University in Massachusetts.

David Dror's experience in social security dates back to the mid-1970s when he was responsible for negotiating a comprehensive pension agreement for private-sector employers in Israel and a nationwide wage-indexation system. He also held key positions on the Council of the National Insurance Institute and served as Delegate to the International Labour Conference (Geneva). From 1981 to 2003 Dror worked for the ILO. From 1989, his work focused on applied health insurance, as practitioner and later as researcher, which included developing innovative pro-poor options for the extension of health insurance in low-income countries. The "Social Re" concept that he developed offers a new approach to sustainable community health financing. Since retiring from the ILO, and with a PhD and DBA, he has been teaching in two universities, conducting and supervising research, and overseeing the implementation of technical support to health insurance schemes for the poor in India, South Africa and elsewhere.

Iddo Dror is a doctoral candidate at the University of Geneva's Faculty of Economic and Social Sciences, where he is researching the provision of health microinsurance in developing countries. In addition to his research, Iddo is actively involved in developing management competencies for international organizations, notably through an innovative MBA programme specializing in international organizations (cf. www.iomba.ch), which he helped create and still coordinates.

Sven Enarsson (BA in economics at Stockholm University) started working in development cooperation in 1970. Has worked with projects in Africa for 15 years, as a field worker, a project leader and a regional representative of the Swedish Cooperative Centre. Employed by the Swedish Cooperative Centre from 1986 to 2003, he has worked mainly in the development of rural and urban savings and credit cooperatives in eastern and southern Africa. He has also supported cooperative banking in Kenya and has lately been involved in cooperative finance and insurance. Sven is now working as a consultant.

Klaus Fischer is a professor of finance at Laval University, Canada. His research focuses on financial institutions with special emphasis on mutual financial intermediaries, and micro finance and insurance in developing countries. He publishes in academic and professional journals presenting funda-

mental and applied research results. Significant recent activities to note are his role as a leader of a three-year project involving researchers from South America, Africa and Asia and as principal researcher in a World Bank-sponsored team research effort, both on the subject of network organizations and the regulation and supervision of mutual financial intermediaries.

Bénédicte Fonteneau is a sociologist and senior researcher at the Catholic University of Leuven (Belgium). Her fields of research include not-for-profit organizations, microinsurance schemes, HIV/AIDS, community-based organizations, and access to healthcare and health systems. Using fundamental and applied research methods, she examines the emergence and the organizational issues of associations dealing with health-related concerns (e.g. access to healthcare, health insurance, prevention and care) and their relations with the health sector at the micro (health providers) and macro level (health authorities). She gives special emphasis to the influence of international cooperation in this context. Her research has concentrated on West Africa.

Bruno Galland is Director of Research at CIDR in the field of participatory microinsurance schemes and the performance of health services. CIDR is involved in the design, implementation and evaluation of health microinsurance programmes in various African countries. By analysing and documenting the experiences of these programmes, CIDR contributes to increasing the expertise and competence of local actors. Bruno Galland has published various practical guides and documents and has organized training with other organizations, including the French Ministry of Foreign Affairs, GTZ, ILO/STEP and CGAP.

Denis Garand (FCIA, FSA) worked for nearly 20 years for a Canadian cooperative insurance company as Group Actuary, Director of Marketing and Vice-President of Group Insurance, as well as an advisor to developing cooperative insurers. Since 2001, Denis has been an independent consultant, focusing on the Canadian group insurance industry and international microinsurance programmes. Canadian assignments have included strategic reviews, capital management, training, product development, pricing, mergers, insurance company start-up and the development of the first Canadian disability incidence study. International assignments for BearingPoint, CGAP, ILO, GTZ, CCA and ICMIF have been in India, Pakistan, Nepal, Sri Lanka, Bangladesh, the Philippines, Benin, Rwanda and Barbados on all aspects of microinsurance.

Christian Jacquier (engineer and PhD) is the Coordinator of the ILO global programme “Strategies and Tools against Social Exclusion and Poverty” (www.ilo.org/step). As a specialist in the extension of social protection, Jacquier helped launch the concept of “micro-insurance” in 1999 through an article in ISSA review (Dror-Jacquier). He serves as the coordinator of the International Alliance for the Extension of Social Protection, composed of ILO, ISSA, ICMIF, AIM, ICA, IHCO and WIEGO (www.social-protection.org) and is a member of WIEGO, a global research-policy network that seeks to improve the status of the working poor, especially women, in the informal economy.

Rüdiger Krech (MPH, PhD) is Head of Social Protection Section at GTZ. He joined GTZ in 2003 and is assigned to numerous national and international task forces on social protection and is a member of the German delegation at the UN Social and Economic Commission. Between 1992 and 2003 he worked at the WHO Regional Office for Europe, where he coordinated the WHO European strategy “Health for All for the 21st Century”, and was the WHO’s focal point for Europe on Ageing. Previously, he worked in child psychiatry before he took up a position as a senior lecturer for health in social work at a German college. Dr. Krech has a professional background in educational sciences, medicine and public health.

Richard Lacasse is currently Program Director for Latin America and the Caribbean at SOCODEVI, a Canadian NGO specializing in cooperative development in Africa, Asia and Latin America. With a master’s in cooperative management, Richard Lacasse has during the past twenty years developed solid experience in planning and implementing development programmes, and partnership-building oriented towards local ownership and economic development. He has recognized expertise in cooperative organizational development, combining the needs for a solid democratic participation and governance with viable economic activities.

Alexia Latortue leads CGAP's work on improving the effectiveness of funding for microfinance. She managed the Microfinance Donor Peer Reviews in 2002, and now provides strategic and technical services to funding agencies. Ms. Latortue has written extensively on aid effectiveness in microfinance. She is the focal point for the CGAP Working Group on Microinsurance. Previously, Ms. Latortue worked with Development Alternatives, Inc. She spent three years in Haiti, managing technical services to financial institutions and working on industry infrastructure issues. Ms. Latortue holds a master's in development economics from the Fletcher School of Law and Diplomacy, Tufts University. She is fluent in French, Creole and German.

Richard Leftley joined Opportunity International in 2002 as insurance product development manager having previously worked as a reinsurance broker for Benfield Greig. Richard pioneered the introduction of insurance products within the Opportunity Network with impressive results: at the end of 2005, a range of insurance products were available to over 2.6 million Opportunity clients and family members in Africa, Asia and Latin America. In 2004, Richard became Vice-President for Planning & Operations and leads a team of specialist consultants providing technical assistance to Opportunity partners in 29 countries. During 2005, Opportunity International launched the Micro Insurance Agency to provide a larger number of clients with access to insurance products; as President of the agency, Richard has established the organization and is setting its strategic direction.

Dominic Liber is a director of Quindiem Consulting and a qualified actuary with many years' experience in providing life insurance product design, risk management, and strategy to insurers, reinsurers, corporations, NGOs, microlenders, industry bodies and other consulting firms. He has been extensively involved in the development of risk solutions for the low-income markets, and the development of pricing models for a range of healthcare, disability, life and business risks including AIDS-related risks. He is the convener of the AIDS Committee of the Actuarial Society of South Africa and author of several manuals and guides on microinsurance and microfinance risk management.

Roland Lindenthal is currently on leave from the German Ministry for Economic Cooperation and Development (BMZ). From 2003 to 2005, he was the Senior Advisor on social policy, employment and labour market policy for the United Nations Support Facility for Indonesian Recovery (UNSFIR). Prior to this appointment, he headed UNDP's Governance Department in Zimbabwe (2001–2002) and was Deputy Chief of the UN Division at the BMZ (1996–2000). From 1991 to 1996, he worked for the Enterprise Development Department of the ILO in Geneva. Mr. Lindenthal has a master's degree in economics.

Philippe Marcadet is the Technical Coordinator of the "Strategies and Tools against Social Exclusion and Poverty" (STEP) Programme of the International Labour Organization. He is also in charge of policy development for the informal economy at the ILO Social Security Department. He leads research, policy and project design, the production of tools and publications, and the provision of technical advice related to the extension of social protection. Prior to joining the STEP Programme in 1998, he worked for 12 years as an expert in several technical cooperation programmes aimed at fighting poverty in Africa and Latin America. He is a development economist.

Michael J. McCord is the President of The MicroInsurance Centre, an organization dedicated to creating partnerships to provide specially designed insurance products to low-income markets. Michael combines experience as controller of a US commercial bank, CEO of an MFI in Uganda, Regional Director for microfinance programmes in Africa, and now the MicroInsurance Centre, to provide a depth of knowledge on developing and managing microinsurance products. His specializations include institutional development, new product development, and assessment and analysis of microinsurance programmes. He has written extensively on microinsurance, as well as on subjects as varied as pilot testing, rollout and the feedback loop for microfinance institutions, MFI accounting and analysis, and the function of laws.

Gerry Noble (MB, DCH, DObs, DTM&H) is an Irish physician and health-financing specialist with ten years' experience in health management and systems development in sub-Saharan Africa. He founded Microcare, a health microinsurer giving low-income groups in Uganda access to quality affordable healthcare. Networking a central Oracle database with computerized clinic check-in desks and client Smart Cards, Microcare integrates on-site client identity verification and real-time

claims processing with centralized insurance management. This prevents fraud, contains treatment costs and monitors quality of care.

Zahid Qureshi is President of International Development & Communication Services, Inc. (ID&CS). His experience includes 23 years with a group of insurance and financial services companies in North America and 12 years of insurance development in various markets for ICMIF, an international organization based in Europe that has member insurers in some 70 countries. His introduction to development work came in San Francisco as an intern at The Asia Foundation, which promotes democratic and self-help institutions. Earlier he had served as a copy editor on two daily newspapers. Zahid has master's degrees in journalism (with a major in international relations) and English literature.

Ralf Radermacher is an economist at the University of Cologne, Germany. Working at the Department for Cooperative Studies, he is involved in research and teaching in the fields of health insurance for the poor, microfinance institutions and cooperatives. In his research, he combines qualitative and quantitative methods as well as experimental economics. His main interest is health microinsurance; the current focus of work is India. Ralf Radermacher also works as a freelance consultant in the area of microinsurance.

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James Roth's work has focused on developing financial services for the poor. His PhD at the University of Cambridge looked at the variety and depth of financial services available to the poor in a small South African Township. His subsequent work has focused on selecting, researching and promoting innovative financial instruments and institutions. He has assisted governments and donors in developing policies conducive to an inclusive financial sector, including work on credit guarantee funds, microcredit and microinsurance. From 2000 to 2004, he worked for the Social Finance Programme of the ILO in Geneva. In 2004, he was Chief Technical Adviser on a microinsurance project in Bangalore, India financed by GTZ and the ILO. He is currently a partner in The Microinsurance Centre, a specialized consulting firm.

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This authoritative compendium brings together the latest thinking of leading academics, actuaries, and insurance and development professionals in the microinsurance field. The result is a practical, wide-ranging resource which provides the most thorough overview of the subject to date.

The book allows readers to benefit from the valuable lessons learned from a project launched by the CGAP Working Group on Microinsurance analysing operations around the world. Essential reading for insurance professionals, practitioners and anyone involved with offering insurance to low-income persons, this volume covers the many aspects of microinsurance in detail including product design, marketing, premium collection and governance.

It also discusses the various institutional arrangements available for delivery such as the community-based approach, insurance companies owned by networks of savings and credit cooperatives and microfinance institutions. The roles of key stakeholders are also explored and the book offers insightful strategies for achieving the right balance between coverage, costs and price.

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