2 Microinsurance products and services

2.1 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.

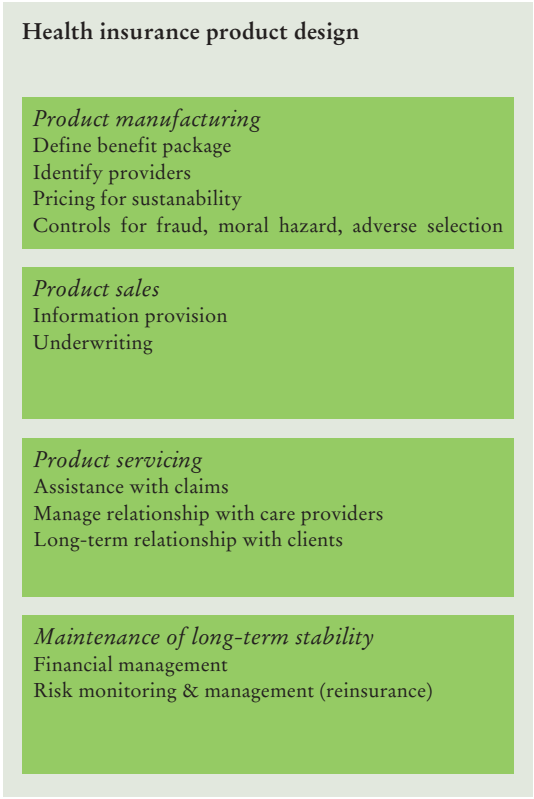
Talking about health microinsurance requires, firstly, agreement on the definition. This chapter defines health insurance as a risk-transfer mechanism under which the insurer assumes a certain risk on behalf of the insured in exchange for a premium. The premiums are paid in advance in return for compensation 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 **Health insurance product design**



1 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 then 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.

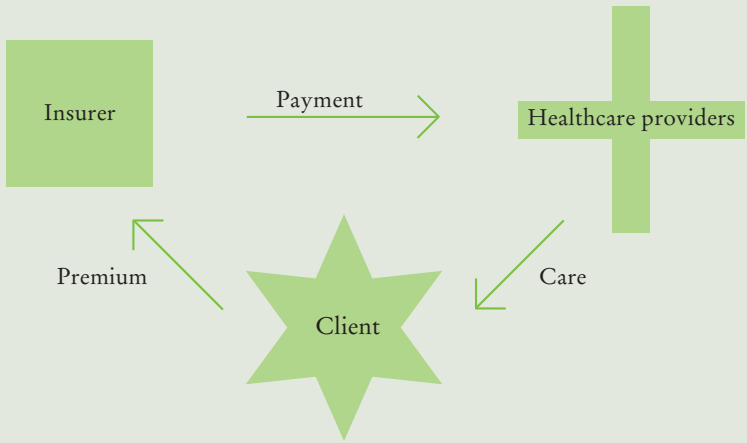
1.5 Define providers

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:

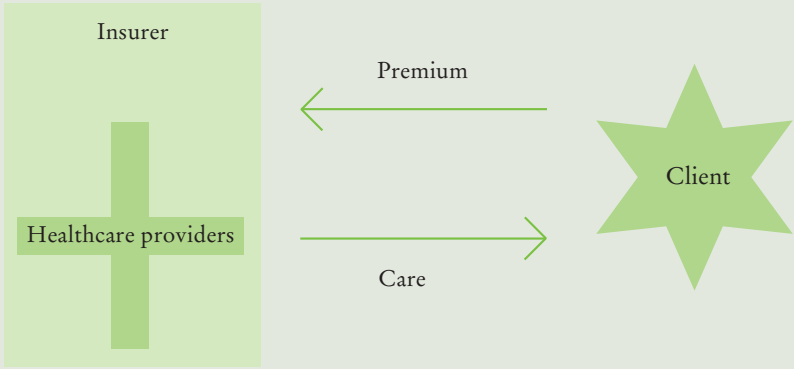
1. The insurers select specific healthcare providers that clients use and conclude a **formal agreement with the providers** *(Figure 7)*. The insurer usually pays the provider directly for services rendered to the client. This solution is based on the benefit-in-kind principle, whereby the policyholder 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

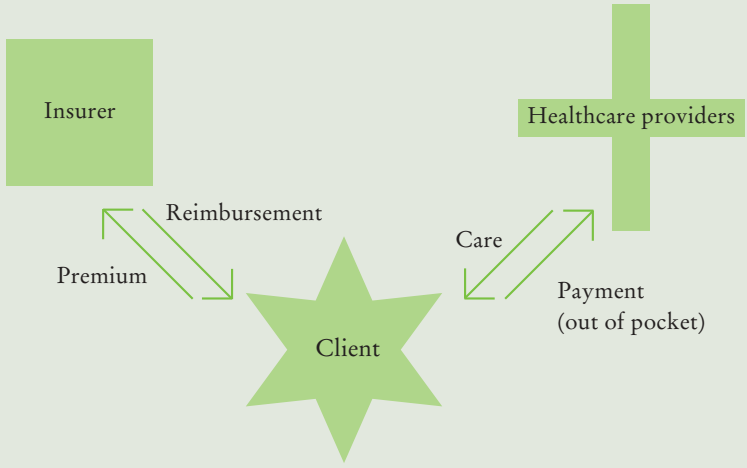
The BRAC Health Programme in Bangladesh is aimed principally at the community, with a particular focus on women and children, though men are not specifically excluded. The scheme is implemented through three tiers. The first tier is a cadre of part-time community health workers, called Shashtho Shebikas (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 reinburses 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 mutuals 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 microfinance 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**

Tasks	*Features*
Determination of coverage adapted to the target group	Demand analysis (direct dimension)
	Feasibility study (abstract dimension)
Actuarial premium calculation	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 Báscio 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**

Tasks	*Features*
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
	Guidance and consulting on health issues
Long-term client relations	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 component[3] 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**

	Claims/ Total premium (%)	*Expense ratio (%) (Total expenses/ Total income)*	*Administrative costs/ Premium (%)*	*Reinsurance premium/ Premium income (%)*	*Renewal rate (%)*
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 schenes. 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**

Tasks	*Features*
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 a 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**

Institution	*Tata-AIG (US$)*	*Delta Life (US$)*
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 microfinance 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.

1 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 x loan principal /52) x 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 overemphasized. 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**

	Product features and policies
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)	· 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 Columna 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**

Benefit class	*Monthly premiums*	
	Minimum LKR 5–15	*Maximum* 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**

Microinsurance organization	*Number of policyholders (voluntary life)*	*Potential size of the market*	*Market share (%)*
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.

2.4 Meeting the special needs of women and children

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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.

1 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 then 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 healthcare 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 then 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**

Scheme 1	*Member*	*Spouse*	*Children*	*Family*
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

Scheme 2	*Member*	*Spouse*	*Children*	*Family*
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.