
4 Institutional options

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I Introduction

The majority of microinsurance providers in the world are mutual institutions of some sort. Mutual institutions are owned by their member-users and respect the “one-member, one-vote” principle.¹ Mutual institutions come in several varieties, including three that emerge from the case studies:

1. *Stand-alone mutual (or cooperative) insurance companies:* These are mostly large mutual insurance companies not affiliated to any network of mutual institutions. CARD MBA in the Philippines and Yasiru Mutual Provident Fund in Sri Lanka are examples of stand-alone mutuals.

2. *Insurance as a business affiliated to a network of financial cooperatives (savings and credit cooperatives or SACCOs):*² An insurance company is affiliated to a network of co-ops, usually savings and credit co-ops, and provides insurance services to members of the network.³ Most large networks of SACCOs also deliver insurance services to their members through such a sponsored insurer. Many of these insurers are members of the International Cooperative and Mutual Insurance Federation (ICMIF). This model is referred to as the cooperative or SACCO network.

¹ The expressions “mutual institution” and “mutuality” used in this chapter refer to both “cooperatives” and “mutual associations”. The technical differences between both these specific forms are discussed in Section 2.

² This chapter uses the term SACCO, which is more generic than “credit union”. The term “financial cooperative” is not used since it often represents both savings and credit and insurance cooperatives.

³ The term “network” applies to apex structures that bind many independent institutions by a long-term contract or alliance to pool resources. For example, SANASA (owner of ALMAO), one of the largest alliances in the world, is composed of 8,500 legally independent savings and credit associations.

3. *Networks of mutual insurance associations:* The network is composed of mutual insurance associations that create apex structures, such as Union Technique de la Mutualité Malienne (UTM); friendly societies associations also operate in this way. This model is also referred to as the community-based approach, which is discussed in detail in Chapter 4.3.

The main difference between the second and third categories is that, for the latter, the mutuals were created solely to provide insurance to their members, whereas for SACCOs, insurance is just an additional product, and often not even considered a core service. This chapter focuses on the second type – insurers for a cooperative network – which includes the institutions summarized in Table 36.

Table 36

Case studies that correspond to the cooperative network model

Country	Institution (# of affiliated SACCOs)	Start of scheme	Persons covered (data from)
Peru	ServiPerú (86)	1994	94 000 (2003)
Poland	TUW SKOK (1 285)	1998	93 000 (2003)
Guatemala	Columna (87)	1993	54 000 (2003)
Various	9 ICMIF member insurers ¹		
Malawi	MUSCCO (57)	1980	56 000 (2003)
Colombia	La Equidad Seguros (1 273) ²	1970	30 000 (2004)
India	Yeshasvini Health Care Trust (25 000) ³	2002	1 450 000 (2004)
Sri Lanka	ALMAO (8 500)	1991	50 000 (2004)
Benin	AssEF (137)	2003	2 000 (2004)
Togo	MAFUCECTO (68) ⁴	1989	n.a.

Notes:

¹ This case study, ICMIF (2005), “Lessons learnt the hard way”, covers nine institutions in eight countries. Confidentiality agreements do not allow disclosure of the names.

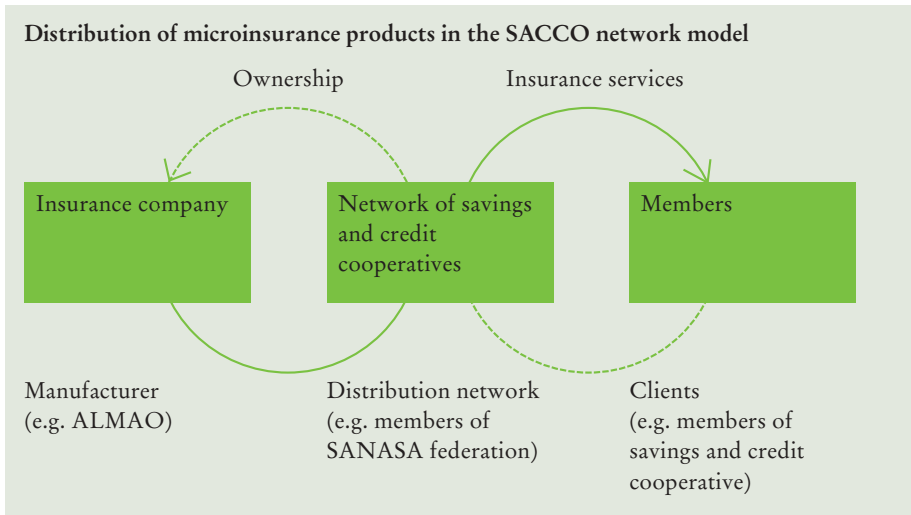
² This includes SACCOs and other cooperatives.

³ Cooperative societies in a wide range of businesses.

⁴ Pilot experience in Togo which if successful will be extended to SACCO networks in Burkina Faso, Benin, Mali and Senegal.

In the cooperative network model there are two key components: 1) a risk carrier, often an insurance company, which creates and underwrites the insurance products and 2) an association of cooperatives (financial and/or non-financial) that serves as the distribution network as well as a more-or-less captive market. Figure 23 illustrates this relationship in a simplified fashion, where the broken-line arrow represents ownership links and the solid-line arrow the flow of services. While the cases cover mostly SACCO networks, the model works just as well for other types of cooperative networks, such as agricultural and consumer cooperatives. Indeed, Yeshasvini is an example of microinsurance being provided through a multi-sector network.

Figure 23



In contrast to the partner-agent model discussed in the following chapter, this arrangement is not a joint venture between two independent organizations contractually engaged to offer insurance products. In the cooperative model, the insurance company is owned and controlled by the network and created for the purpose of delivering insurance services, to the network initially and then to other segments of the market as the company gets established. This distinction has important implications for the quality and cost of services provided to low-income segments (*see Box 67*).

While the main purpose of the insurance affiliate is to service the membership of the SACCO, it may also offer insurance products for the cooperatives themselves. For example, as described in Chapter 3.8, TUW SKOK was initially created by Poland's National Association of Credit Unions to provide deposit insurance and other corporate covers for the savings and credit unions; only after several years did the insurer introduce products for the SACCO members.⁴

Box 67

Why cooperative insurance suits low-income markets

In 1977, UNCTAD passed a resolution endorsing cooperative insurance. Referring to the study entitled *Cooperative insurance: A suitable form of insurance for developing countries*, it called on multilateral and other aid institutions to “respond to requests of developing countries for technical assistance in the promotion of cooperative insurance”. Among the study's findings are reasons why cooperative insurance is particularly suitable for low-income segments of the market:

⁴ In the case of Yeshasvini, the Trust is mainly controlled by the Department of Cooperatives rather than the co-ops themselves. Though a unique case, this experience illustrates that cooperative networks can be useful under a variety of contexts.

Affinity

A cooperative is essentially an organizational instrument for enabling small producers and consumers to pool their resources to secure the economic advantages of scale – as individuals, they essentially have no voice, but collectively they can achieve significant results. This principle is particularly applicable to insurance, which is based on spreading risks over as large a number of insureds as possible.

Accessibility

The cooperative organizational form covers many different sectors – including agricultural production, fisheries, marketing, processing, handicrafts, retailing, storage, transport, savings and loans, and home ownership. A cooperative insurer is in a position to cater for a wide range of basic needs and can reach farmers in remote rural areas as well as lower-income groups in towns and cities.

Affordability

There are many reasons why cooperative insurers can reduce their total costs, and hence premium rates, below those of private insurers. A cooperative insurer can dispense with a special sales force and with commissions; it may conduct a sales campaign for an entire village through an existing agricultural co-op, or direct-market various covers without agents through savings and credit cooperatives. Through use of the local society and network, premium collection and claims settlement procedures are simple and cost-effective.

Investment in community

Cooperative insurance facilitates savings and accumulation of capital in the lower-income brackets, and channels a portion of these funds into the local trade and industry, helping to improve living standards.

Ownership

Policyholders are also owners of cooperative insurance enterprises. The parliamentary structure stemming from cooperative principles offers them a real opportunity for direct control over decision-making. They have a special interest in health promotion and loss prevention, for their interest is not only in personal insurance but also in protecting the society's assets they jointly own.

Source: Adapted from UNCTAD, 1977.

The cooperative model takes this basic shape in most countries, developed and developing alike, where the cooperative movement has taken hold. What is more, the model is self-adjusting, adapting to the standards and requirements of the membership of the SACCO network. In networks dominated by middle-class people (e.g. southern Brazil's SICREDI), its products will tend to suit that market. If the network is rooted in low-income members, the insurance products will be adapted to that clientele. If the services are not adapted to its members' insurance needs, failure can ensue. For example, at ALMAO, regulatory restrictions are imposing a higher cost structure, which in turn has encouraged the design of higher-margin, up-market products that moved the insurer away from its clientele; not surprisingly, the products are not selling very well.

Decades ago, cooperative and mutual insurance took root for low-income people in what are now developed countries. In Canada, following the Great Depression when insurance for low-income households was inaccessible and unaffordable, two separate cooperative insurance schemes emerged, each bringing together savings and credit cooperatives, marketing/supply and consumer cooperatives, farmers' associations and trade unions. In many developing countries today, similar structures are emerging.

However, the model is not trouble-free. In some countries, a cooperative insurer may have the network's second-tier representation on its board of directors, but its microinsurance is run in concert with the managements and boards of only a handful of primary cooperatives in the network. This is the case of ServiPerú and La Equidad. Both have microinsurance programmes that are sustained in effect not by broad participation of the network, but through direct dealings with only a few network members. Moreover, La Equidad's sales of microinsurance through a non-cooperative MFI, Women's World Forum, were more successful than those through the participating cooperatives. These irregularities are often related to the particular history of the supporting network or the circumstances under which the insurance affiliate was created. If the governance structure is weak, the result may be management entrenchment and an outcome less adapted to the needs of co-op members.

The use of other distribution channels by a cooperative insurer may appear confusing and be perceived as a sign of independence from the cooperative network, but it is not so. It does not dilute the network's ownership, just as the use of multiple distribution channels by a privately held insurer would not affect its shareholding. Besides, cooperative and mutual insurers' forays into non-cooperative sectors usually involve affiliation with organizations that are like-minded and popularly based – operated with the interests of customers rather than those of shareholders at heart.

2

What is a mutual insurer?

There are two basic types of insurance company: joint stock and mutual. A **joint-stock company** is owned by investors, among whom profit is shared through dividends. A **mutual company** is owned by its customers. After deductions for reserves, profits are distributed to customer-owners usually in proportion to the business they did with the company.

Mutual insurers can be classified into three types. The first one requires neither a premium nor an assessment of policies. In this type of organization, also called post-paid, claims are charged to members after the event. This form was common in the past, but is nearly extinct today because members must be sought out after each event and the fulfilment of obligations weakens as social ties loosen. The second type has premiums and assessable policies, while the third has premiums and non-assessable policies. In the latter, policyholders receive dividends, but additional assessments are not levied for losses (i.e. they share the surpluses, but not the losses). Not surprisingly, regulators require higher levels of retained earnings and reserves for the third type. The second and third types are quite frequent today. Most mutual insurers covered in this chapter are of the third type; mutuals covered in Chapter 4.3 tend to be of the second type, with the members sharing the risks and returns.

In countries with a strong self-help and cooperative tradition, an insurance company or society can be incorporated as a **cooperative**. While both are self-help, self-responsibility and self-governance institutions, the difference between mutuals and cooperatives lies in the ownership structure. A mutual insurer must be owned by its policyholders. However, a cooperative insurer may be owned either by its customers or by cooperatives (second-tier institutions) that may or may not be its customers. In other aspects, such as marketing, community involvement, staff participation and welfare, mutuals and cooperatives have the same ethos. In some cases, a “cooperative” insurer will actually be a joint-stock company for the strategic or regulatory reasons discussed in Section 6 of this chapter.

Insurance companies adhering to cooperative principles have different roots in different countries, but share some characteristics:

- **Democratic control**, underpinned by education of the customer base, with policy-owners involved in governance through delegates and working groups
- **Limited return on equity**, patronage dividends and other cooperative principles

- **Affiliation of founding members** and most policyholders to social, community or professional institutions
- **Promotion** of health, safety and loss prevention to reduce the costs of insurance
- **Influence** over the insurance industry and policymakers in the interest of policyholders

3 The cooperative difference

How are these cooperative characteristics reflected in actual operations, and what sets the insurers apart? Here is a look at five of the cases in Table 36:

1. *ServiPerú*

Its microinsurance product, Previsión Familiar, provides funeral and health services to low-income households. Its benefits are in kind, in the form of a service (healthcare and funeral) through ServiPerú's own medical centre and funeral company, instead of a payment or reimbursement of expenses. This approach overcomes some of the market's inherent aversion to insurance, permits greater control over the quality of services, and helps accommodate specific characteristics of the microinsurance market. Besides door-to-door monthly premium collection to enhance accessibility, the cooperative has a service approach that treats the poor with respect. Low-income people who are used to being treated poorly in medical clinics are extremely appreciative of the consideration provided by staff at the Servisalud.

2. *Seguros La Equidad, Colombia*

This mainstream insurer of more than 3 million people has two specialized products covering some 30,000 low-income persons. It operates under the supervision of the Superintendent of Banks and is registered under the Cooperative Law. La Equidad distributes its surplus to its members based on their use of the insurance services, not on the basis of their capital investment.

The Cooperative Law requires that 20 per cent of any surplus be dedicated to education. In 1990, the company set up the La Equidad Foundation for the Development of Solidarity to carry out its community responsibilities in four areas: a) cooperative leaders' training, b) cooperative education, c) publications and d) social contributions. Cooperative leaders' training, targeting the youth, is designed to ensure that in the future the cooperatives are well administered by people with high professional skills and social values. Cooperative education is especially for board members of the organizations associated with La Equidad, focusing primarily on improving their performance.

3. *Columna, Guatemala*

When this insurer was created by the SACCO federation and nine member cooperatives in 1994, the board decided that any surplus generated during the first five years would be added to retained earnings rather than paid back to shareholding cooperatives as dividends. This was a difficult decision, as the cooperatives were invited to invest in the venture as a business opportunity and did not fully appreciate that an insurance company requires a lot of capital to grow. They wanted a good return. Since 1999, 50 per cent of the net surplus each year has been added to the shareholders' capital and the other half paid to them as dividends. This arrangement has strengthened the insurer while generating returns for its cooperative owners. Columna has also involved the sponsoring cooperatives in claims processing and product development.

4. *TUW SKOK, Poland*

This mutual insurer's mission is to identify the insurance needs of its members – cooperative savings and credit unions and *their* members – and provide high-quality insurance products which meet such needs. TUW SKOK provides credit unions with deposit insurance and loan protection, fidelity bonding, and coverage for robbery and fire; the insurer also provides credit union members with a number of personal insurance products. Deposit insurance offered by an apex affiliate is an unusual arrangement, partly due to the regulatory environment found in Poland. SACCOs are required to buy deposit insurance from TUW SKOK, which gives the insurer a guaranteed stream of premiums with no acquisition costs. Most credit unions also source other corporate policies from the insurer. As a mutual insurance company, TUW SKOK is not allowed to declare dividends. Surpluses are generally used to build up capital and reserves, but are sometimes remitted to credit unions in the form of premium refunds. In 2003, for example, TUW SKOK's board of directors, on behalf of its owners, decided to refund deposit insurance premiums to credit unions that had recorded satisfactory claims experience over the previous three years.

5. *MUSCCO, Malawi*

SACCOs were promoted by the church and government in Malawi in the 1970s to serve people ignored by commercial banks. In 1980, a national association, MUSCCO, was formed to provide support services to them, including mandatory loan protection and life savings schemes. Both of these are credit-union-pay products, which makes MUSCCO's system for premium collection effective. The premium for all eligible loans and savings balances for the 55,000 members is paid by the SACCOs quarterly in advance.

Though credit-union-pay products like these overcome one of the most significant challenges of microinsurance – collecting premiums from low-income people – MUSCCO has found that, in practice, collecting from even 57 corporate customers can be difficult. Only a third of the SACCOs can be described as disciplined customers; considerable time and effort has to be expended on chasing the remainder for payment. However, the insurance contract does provide for benefit payments to be withheld until the premium is paid.

4 Insurance development models and stages

The cooperative model of insurance actually involves different institutional and regulatory arrangements. Based on the experience in a variety of countries, Reinmuth et al. (1990) describe an institutional development plan in which the insurance services offered through the network to the SACCOs and their members become increasingly formal and complex over time, as the organization builds up capacity and human and financial resources. They describe three institutional options: the agency model, the risk-bearing department and an insurance company, which often represent different stages of institutional development for insurers serving SACCO networks.

4.1 The agency model

The SACCOs' national federation or affiliated organization could create an insurance agency that it owns and controls. The agency retails insurance products, which are provided by a local underwriter (i.e. a risk-bearing insurance company) or several underwriters. The agency provides services to members in its name and is paid a commission by the underwriter. The principal advantage of the agency model is that the federation does not bear any risk. An example is the NUCS (National Union of Cooperative Societies) Cooperative Insurance Services launched in Jamaica in 1984 with share capital provided by the Jamaica Cooperative Credit Union League.

4.2 Risk-bearing department

With experience as an agent for other insurers, it may make sense for the national federation to set up a department of its own to provide a group insurance scheme through member cooperatives. This step requires more capable staff, greater capital, cooperation with a reinsurer and, of course, acceptance of a degree of risk. However, with the risk comes the potential reward of a greater return. An example was the Mutual Protection Service of

FENACOAC, the national SACCO federation in Guatemala. This risk-bearing department offered covers for loan protection, life savings, funeral expenses, group life for directors and employees, family life, and fidelity bonding and theft insurance. The department was the precursor of Columna. MUSCCO's insurance scheme is currently structured in this way.

4.3 Insurance company

The services offered through a risk-bearing department tend to be quite basic. As the needs of SACCOs and their members evolve, however, they will probably require more complex coverage that can only be offered through a regulated insurance company. With an abiding commitment, financial means and realistic prospects of picking up business readily, a national federation may formalize this department by creating a fully fledged insurance company that meets all legal requirements, including minimum capital and approval of the superintendent of insurance.

For example, ALMAO's origins are linked to the insurance department of the Sanasa movement and an insurance brokerage set up to serve the needs of the Sanasa societies and their members. Without donor support, the movement was able to mobilize sufficient funds and expertise to create a life insurance company in 2002 and a general insurance company in 2005.

5 Insurance products offered under the cooperative network model

Mutual insurers offer practically every possible insurance product, but most of these multi-line insurers, like ICMIF members, do not focus on the low-income market. Specific networks of mutuals serving the poor tend to offer only a few or perhaps even a single product. At that end of the spectrum, mutual health organizations (MHOs) specialize in health insurance, while at the other extreme, some mutuals may offer a product menu resembling that of an investor-owned insurance company.

In general, the range of products being offered to the low-income market through SACCOs is limited. The original intention of SACCO networks for creating insurance affiliates was to complement the range of financial services they offer, namely savings and loans. This implies that loan protection, or credit life (ensuring that "the debt dies with the debtor"), is almost always offered under this model (see Table 2). This product serves the risk needs of both individual members and the SACCOs themselves. Life savings coverage is another key product offered by SACCOs because it too corresponds with the co-ops' core services.

Another reason why the microinsurance product menu of some SACCO network insurers is limited is that these schemes were often seeded and supported by technical assistance providers, including CUNA Mutual, that chose to promote very basic and simple coverage. This choice made sense, particularly given the limited development of the SACCOs' networks. In addition, offering the same basic products everywhere was an efficient replication strategy. Where the networks and its insurance affiliates have been able to build up the capacity to do more, such as in Colombia and Poland, the basic products serve as a foundation for more useful covers; whereas in Malawi, where capacity remains limited, the network has stayed with the basic package.

The evolution expanding the line of insurance services is important not just because the insurer is addressing a variety of different needs, but also because it can improve the relationship between the insurer and its distribution network. An interesting distinction exists in the cooperative insurance model between cover that is paid for by the SACCOs and member-pay products. Although SACCO-pay products such as loan protection and life savings are an extremely efficient way of providing protection to low-income households, some SACCOs come to see the premium as an expense that they would prefer not to pay – which may partly explain why many SACCOs in Malawi have delinquent premiums. Consequently, it is important for insurers to consider introducing member-pay products that can generate commission income for the SACCOs, which enhances the alignment between the interests of the insurer and the distribution channel.

The alignment of interests is particularly effective when the member-pay product supports a savings or credit product provided by the SACCO, such as the savings completion insurance provided by TUW SKOK (*see Chapter 2.2*). Not only does the SACCO earn income from insurance sales, but the insurance feature helps to market the savings product. In contrast, the only example of endowment products offered by the cooperative network model is ALMAO, and it is not particularly successful with these products. One explanation for the lack of success is that, with such a product, the insurer is essentially competing with the SACCOs for the members' savings – a conflict of interests rather than an alignment.

A particular feature of the mutual model is the ongoing dialogue between the insurer and its distribution channels, which are also (often) its owners. For example, Columina performs annual reviews of insurance sales by the SACCOs that provide an occasion for dialogue about new products and changes that could be introduced. Offering a variety of insurance products has a number of advantages for SACCOs: it encourages the cross-use of

products, increases fidelity and generates commission revenues (if it is a client-pay product for which the SACCO acts as a sales agent).

Table 37

Insurance products offered by SACCO networks

	<i>Loan protection</i>	<i>Life/Life savings</i>	<i>Funeral service</i>	<i>Health</i>	<i>Disability</i>	<i>Other</i>
ServiPerú	x		x	x		x
TUW SKOK	x	x	x		x	x
Columna	x	x			x	
MUSCCO	x	x				
La Equidad	x		x		x	
Yeshasvini				x		
ALMAO	x	x	x	x	x	x
AssEF				x		
MAFUCECTO	x		x			

6 Why mutuals develop networks and how they work

Most mutual financial intermediaries (deposit or insurance) are associated with a macro or inter-mutual organization. Often they organize complex alliances capable of offering a range of financial products. These alliances are institutional devices to control the market risk facing the mutuals' members. Inter-mutual alliances are so vital that they may serve anywhere between a few thousand to a few million members and offer a surprisingly rich range of financial services. The size is very important for (i) the performance one can expect in terms of outreach and sustainability and (ii) the role of the legal and regulatory framework for inter-mutual alliances. Countries with large, successful networks are typically places with a supportive legal and regulatory environment.

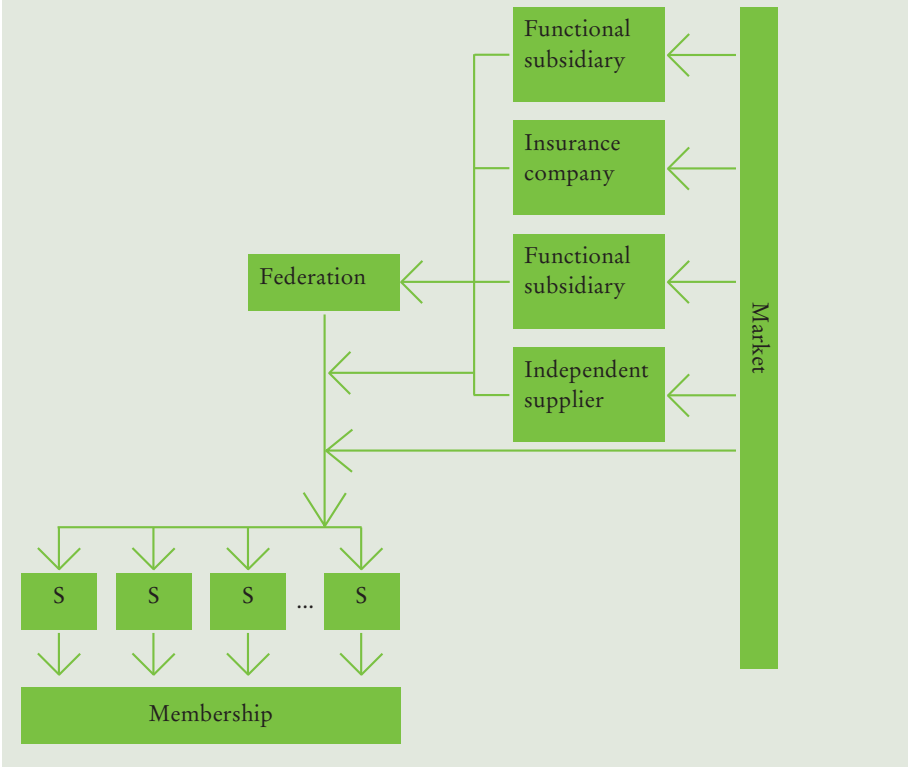
Mutuals create alliances and form collectives (also called federations, unions, etc.) to give members a greater voice in and control over the uncertainty associated with accessing services. Without this collective effort, the members have limited bargaining power with suppliers, leaving them to face expensive and low-quality products and the risk of opportunistic behaviour on the part of the suppliers. Thus, they create a "supply alliance".

Figure 24 provides an illustration of the institutional structure (where "S" represents a SACCO). The members of the cooperatives are owners of the entire structure. The cooperatives in turn form a federation to manage the pooling of resources and procurement of inputs required by the network. To accomplish this, the apex creates functional subsidiaries, such as an insurance company, designed to create products and services for members that are

more favourable than those available in the market.⁵ For some inputs, the apex pools procurement through a long-term contractual arrangement and gains economies of scale while protecting members from the risk of opportunistic behaviour on the part of suppliers.

Figure 24

A mutual network structure with its portfolio of functional subsidiaries



The ownership of the subsidiaries varies. Sometimes it may be a cooperative (e.g. La Equidad), in which case it is considered a third-tier cooperative. At the primary level, a SACCO has individual members. The second tier has a regional or national association serving a number of primary cooperatives. This apex body – or bodies, if cooperatives in sectors other than savings and credit join in – sponsors and controls an insurer on behalf of member cooperatives.

⁵ In countries where the sophistication of financial markets puts more pressure on the network, the portfolio of functional subsidiaries may include dozens of entities, held in all sorts of ownership and holding arrangements. As demand for financial services at the base of the system (members and cooperatives) evolves, the apex will typically incorporate additional functional subsidiaries. Equity for these investments will generally be provided by the cooperatives at the base or by other functional subsidiaries that may have surplus capital available.

The use of joint-stock ownership is becoming increasingly popular (e.g. ALMAO, Columna). In fact, many “mutual” and “cooperative” insurance companies actually have joint-stock ownership, but are referred to as mutuals because their ultimate owners are not individual investors but mutual institutions. The joint-stock form is appealing because of its flexibility in raising capital and for engaging in mergers, acquisitions and joint ventures. These transactions are all useful in expanding the range of products offered to members if the need arises. Also, the joint-stock option is sometimes the only ownership structure the regulatory framework allows (for example in Peru and, ironically, in China and Russia). The risk is that, as these companies grow, they may forget their roots and behave like normal stock companies. In doing so, they risk the loss of their comparative advantages of proximity and putting members/clients first. This sometimes poses a challenge in terms of governance and ensuring that the insurer remains committed to serving the specific needs of the SACCO network members.

Other variations are possible. When a new insurance law in Peru (1993) barred cooperative institutions from offering insurance, the insurance company of the Peruvian SACCO network, SEGUROSCOOP, transformed itself into ServiPerú, a cooperative offering social services (funeral and health protection services). It transferred the insurance portfolio to a joint-stock company and created a subsidiary insurance broker to distribute products that it helps design. Taking advantage of adversity, the insurance affiliate managed to keep the same line of business despite regulatory obstructions while expanding its product line (the social security services).

More recently in Ghana, when the regulator called into question the informal risk management programme of the savings and credit cooperatives, the apex formed a joint venture with a newly registered and licensed cooperative insurer, Unique Insurance Company Limited, owned and controlled by the trade union movement. The insurer, underwriting the cooperatives’ risk management programme, lent it the required compliance while gaining a new market segment. This was essentially a partner-agent arrangement. What made it cooperative was the venture’s ownership. The insurer and the cooperative apex opted for a 50/50 sharing of the venture’s expenses as well as profits, with a joint management group overseeing the programme. The savings and credit cooperative apex had stepped out of its umbrella cooperative network, and so had the trade-union-sponsored insurer, to create a distinct, microinsurance-led network of their own.

These variations illustrate the flexibility of the cooperative network model to adapt to a diversity of economic and regulatory environments, without changing its essence. The organizational design of a particular institution will depend on the history of the SACCO network, how the affiliate

was created/acquired, regulatory restrictions and opportunities available in the marketplace.

The basic organizational structure of a network, regardless of cultural or economic context, replicates the governance features of a mutual at a second level. The executive structure comprises governance (general assembly and board of directors) and regulatory (supervisory committee) bodies. The executive structure (bureau) is responsible for implementing decisions and managing the procurement and delivery of inputs to members. In these structures, individual policyholders are removed from ownership, but are often assured of a voice through a dedicated channel in the democratic control structure. For example, a policyholder advisory committee brings together representative members to receive progress reports, provide input on specific matters and review forecasts on financial results and expected patronage dividends. In addition, some cooperative and mutual insurers may allocate a seat on the board for a policyholder representative.

The analysis of the dynamics of network formation in mutual institutions has important policy implications:

- Attempting to create mutuals without supportive network structures can lead to mediocre results. Individual SACCOs would ordinarily be unable to raise capital to create an insurance company to serve its members. Thus, unless the SACCO is part of a network, the benefits described in this chapter are unachievable.
- When mutuals are created with an integration structure that supports their development, they have the potential to become impressive market players, covering larger numbers of people and thus expanding outreach. Furthermore, these support structures improve sustainability and reduce insolvency risk. For example, TUW SKOK's deposit insurance benefits significantly from the fact that the national association of Polish credit unions closely monitors the performance of its members and has a stabilization fund to assist SACCOs experiencing difficulties.
- Mutuals and their network structures need an appropriate legal framework. Indeed, many SACCO networks operate in unsuitable environments that hamper the development of mutuals and their networks, such as Argentina and Uruguay where the regulatory framework led to the destruction of the networks' structures followed by a massive reduction in market share. Many of the difficulties encountered by ServiPerú's predecessor in the 1990s are due to the unsuitable regulatory framework that emerged in the post-crisis reforms.

7

Advantages and disadvantages of the model

This section presents the main lessons relating to the delivery of microinsurance through the cooperative model. Mutual institutions have weaknesses. There are literally hundreds of thousands of them in the world, and so there is bound to be more than just a few failing to deliver. However, most problems are remediable, if not avoidable.

Some of the most significant **problem areas** are:

1. The poorest of the poor may not always benefit (but often do).

This is a classic criticism of the cooperative model. Mutual institutions are the chosen financial intermediary of a very large range of social sectors, sometimes reaching quite high up the income ladder. However, mutual institutions are also found at the bottom of society and reach hundreds of millions of people who do not have access to other financial institutions, particularly in rural areas where even the most aggressive alternative institutions are often absent. This feature in fact allows mutuals to cater for poor segments of the population without necessarily compromising their own sustainability. The frontier of their outreach is defined by their ability to activate their members' potential to help themselves.

2. Insurance products may be too limited as they tend to be tied to credit products.

This is largely true, particularly in networks that are relatively new, with a low level of integration, or few financial, human and technical resources available (e.g. Columna, MUSCCO, MAFUCECTO). As integration and trust among co-ops develop,⁶ financial resources and technical expertise accumulate, allowing the network to expand the range of financial products, including insurance. The range of products offered by La Equidad, for example, rivals that of commercial insurers in Colombia (although the case study only describes those products distributed to the low-income market).

3. Leaders may be inclined to squander member capital.

There is no direct evidence of this behaviour in the case studies, with the exception of the criticism advanced in *Lessons learnt the hard way* (ICMIF 2005). Indeed, it is not unusual for a SACCO network to have a frail

⁶ This usually involves the development and financing of network governance bodies and control mechanisms that ensure that the network members' conduct is in accordance with the terms of the alliance.

governance structure. This results in weak control of agents (managers) at the apex and they may thus engage in expansionist practices with little regard for protection of the members' wealth.⁷

4. The success of a mutual insurer is tied in with the success of the cooperative network.

This is unavoidable, since the very *raison d'être* of the "functional subsidiaries" is to service the network. While it is not unusual for them to develop some business activity outside the network, it usually represents only a fraction of turnover. The bulk of business tends to remain within the network. ServiPerú is a case where the microinsurance service provider survived a severe crisis of its supporting network in the early 1990s.⁸

5. Risks may not always be properly separated (firewalls).

This can be a severe problem that must be addressed by regulators. In the absence of appropriate supervision, there may be a temptation to mix credit and insurance risk resulting in a high likelihood of failure. MUSCCO is a case where separation is weak and it could break down under stress.

6. Entering into dangerous business uninformed.

While not specific to networks of SACCOs, this must be prevented. If the network is small, it may not be able to raise the necessary funds to acquire the required skills, such as actuarial services. Company 4 (in ICMIF 2005), a "worst practice" example, was set up as a SACCO insurer, but ended in failure. MAFUCECTO has had a bumpy history, enduring several restructurings with international support. While the solution to this problem does not lie with regulators, they can play an important role. As in the previous problem area, the regulatory framework should ensure that insurers are created after consideration of all risks and under the leadership of qualified individuals.

However, the model does have some eminent **advantages**:

1. Low "hold up" risk for insured individuals.

Hold-up risk refers to the possibility that a contractual party may fail to meet its obligations. Poor people are particularly vulnerable to hold-up risk

⁷ This is known as "expense preferences" behaviour or "agency costs". The severity of this phenomenon in mutual institutions – largely due to the high diffusion of ownership, and at the root of most failures – is well documented in the research literature.

⁸ This crisis resulted in the failure of the network's central cooperative bank, other functional subsidiaries and several of the largest S&L co-ops. It led to a fall in assets in the networks of nearly 50 per cent.

because of low social capital and the inability to defend their rights in courts. The fundamental difference between an insurance contract offered by a joint-stock company and that offered by a mutual institution is that in the latter, the insured is also the owner of the insurance enterprise. While investor-owned insurance enterprises may stop offering services, engage in discrimination and even resist honouring claims when they see fit to do so for strategic reasons, these practices are limited in a mutual institution. It is not a matter of ethics, but of basic economic incentives (*see Box 68*). Ownership of the insurer by the insured serves to control the insurer's actions so that they are aligned with the interests of the members/owners.

Box 68

Management of lapses and claims: The mutual difference

To illustrate the differences in incentives, consider the dilemmas facing Delta Life, an investor-owned insurer, and MAFUCECTO (and other mutuals). According to McCord and Churchill (2005), Delta Life has an “ambivalent attitude” to lapses. While the company is committed to social objectives, it benefits financially from lapsed policies where there is no obligation to repay the accumulated savings. Furthermore, the lapse allows the company to screen periodically the insured customer by requiring a new certificate of health. Thus, owners and staff face the contradictory objectives of profits and customer service. Under financial stress, it is likely that the balance will tilt in favour of protecting shareholder returns at the expense of customer benefits.

MAFUCECTO prevents lapses through automatic deductions from members' accounts. So do La Equidad (by debiting the loan or savings account, or through direct wage deposits) and TUW SKOK (debits to accounts). Obviously this is an advantage associated with the model of combining savings and credit with insurance products. However, even in the absence of this link, mutuals treat lapses differently. MHOs (covered in Chapter 4.3) do not use lapses to screen clients. Lapsed members may have to enter a new waiting period, so as to prevent opportunistic behaviour by members who may seek to manage lapses strategically, but they are not re-screened. In fact, lapses in an MHO, instead of procuring a financial advantage, represent a key instability factor.

The same is true of claims management. At Delta Life, when a death occurs, the beneficiary is responsible for notifying the insurer. In the case of MAFUCECTO, the SACCOs seek out beneficiaries to inform them of their rights and help them in the preparation of claims.

This exceptional behaviour has little to do with business ethics and much to do with the fact that members own and govern the institution. The general assembly of the SACCO would not have condoned any other behaviour than that of seeking out the best interest of the owners. This interest implies

not encouraging lapses, but preventing them, and not ignoring failed claims, but seeking them out. This duality of incentives is accentuated in poor communities where profit margins on individual policies offered by investor-owned firms are very small, and where individuals have no means of enforcing contractual rights. In a mutual institution, even in poor communities, the member, as owner, is always right. The board of directors of MAFUCECTO is composed of members of the board of directors of the SACCOs (themselves members of the cooperative). Thus, throughout the governance structure, the interests of the members are protected (but see problem described under 3, on page 351).

2. Potential access to large numbers of people in a large variety of cultural and economic environments.

Often SACCO or other cooperative networks can be quite large, reaching from tens of thousands to millions of people through member co-ops. Yeshasvini was able to reach 1.6 million clients in just a year! Furthermore, the presence of the model in every continent demonstrates its versatility in adapting to different cultural and economic environments. Owing to the large potential and “captive” customer base, insurance companies can exploit economies of scale (which was one of the main purposes of creating affiliated insurance companies), achieving break-even and becoming viable quickly.

3. Availability of risk capital for investment purposes.

Equity for the creation of insurance affiliates is from the members of SACCOs, financed either through a direct investment or by ceding capital to an apex, which in turn invests in the insurance affiliate. SACCOs tend to accumulate a surplus of liquidity and capital as they mature, particularly if they are operating in a healthy economy. Thus, these networks constitute an excellent source of risk capital to finance insurance and expand the range of services provided by the SACCOs. In eight out of the nine cases presented in Table 37 (Yeshasvini Health Care Trust, a foundation, is the exception), the start-up capital of the insurance affiliates was provided by SACCOs, with or without some external participation. On the other hand, mutuals cannot raise capital in the stock market. However, there is no restriction on joint ventures or the issue of bonds.⁹

⁹ This is a complex debate. A stand-alone mutual cannot issue stock, which limits the growth potential of mutual insurers. However, when the insurance enterprise is an affiliate of a SACCO network, its ownership structure can be adjusted to suit different financing options. Most networks have chosen not to list affiliates in the stock markets, but some have, thereby leveraging network-generated capital. Usually the network keeps a controlling share of the voting stock. Thus, joint ventures appear to be a more flexible form for leveraging capital from SACCO networks.

4. *Limited need for donor funding other than technical assistance.*

In connection with the previous point, the SACCO network can often provide capital to create/acquire the insurance affiliate, provided the regulatory framework does not put the minimum capital requirements out of reach of the network. External funding in these cases may be welcome as a joint venture, especially if this comes with technical support, as was often the case with CUNA Mutual,¹⁰ but funding is not essential. However, donors can make a big difference by providing technical assistance to train staff in the complexities of managing an insurance enterprise. This has been the case of Columna, for example, where technical assistance from, and strategic partnerships with, SOCODEVI and AAC/MIS have been a key element in the company's development, and MAFUCECTO where DID and CIF have played essentially the same role (see Chapter 5.5).

5. *Investments have a development effect as income returns to the community.*

Since the equity of the insurance affiliates is held by co-ops – either directly or indirectly through the apex – the funds generated by the insurance activity are eventually returned to their members. As the size of the portfolio of functional subsidiaries increases, so do the network's assets. If these assets are managed prudently, the cash flows they generate will be used to benefit the network and its members. For example, because of regulatory restrictions, TUW SKOK cannot pay dividends to shareholders. Although some profits are remitted to the SACCOs in the form of premium refunds, the insurer has also built up sufficient capital to buy a life insurance company and thus expand the range of services to its members.

6. *Access to reinsurance.*

As described in Chapter 5.4, access to reinsurance is a serious constraint for many microinsurance providers. However, those that provide microinsurance through SACCO networks have the necessary know-how to access reinsurance through upstream alliances. ICMIF has played a central role in facilitating access to reinsurance for its member networks. Therefore, most mutual insurance structures are likely to have access to some reinsurance in international markets – usually, but not exclusively, with other mutual insurance firms in the world.

¹⁰ For example, in 1993, CUNA Mutual and the Foundation for Polish Credit Unions (FPCU) launched Benefit, a joint venture that provided loan protection, life savings and funeral insurance. Along with technical assistance, CUNA Mutual provided 90 per cent of Benefit's initial capital. After four years of operations and moderate success, the partners decided to go their separate ways. However, by then, the Polish credit unions were well on their way to developing the impressive portfolio of insurance products they offer today.

8 Conclusion

Mutual insurance firms are ubiquitous and versatile institutions. This chapter focused on one type of mutual model, in which a network of savings and credit cooperatives creates its own insurance company (or agency, or a department of the network) to meet the insurance needs of the co-ops and their members.

The following features can be gleaned for insurers affiliated to mutual networks: i) the model appears frequently and in a wide variety of cultural and economic environments; ii) except for a few minor variations in organizational structure, often conditioned by local regulatory constraints, the examples present a constancy of operational characteristics and institutional arrangements; iii) by and large these structures work free of any subsidy; iv) institutions often have access to reinsurance, addressing a common problem for microinsurance providers; and v) while the examples are based on financial cooperatives, this model works similarly for other types of cooperatives as well.

Not only is the SACCO network model financially viable, but it is robust and potentially applicable to providing microinsurance services to poor people in a wide range of situations. Overall, the SACCO networks are versatile mechanisms for delivering various insurance products to relatively large numbers of people. However, individual structures tend to specialize in insurance products that complement the SACCOs' savings and loans portfolios. This is one of the weaknesses of the model. Another risk is that large companies may forget their roots and behave like stock companies, losing their comparative advantage.

These conclusions suggest that this organizational form is suitable whenever there is a network of savings and loans cooperatives on which to build the insurance business. Given the potential of the model, it would make sense to exploit its strengths and minimize its limitations, for example by developing clear guidelines for business plans that include financing modes, enhancing governance arrangements (links between the network and the insurance business), creating firewalls and developing insurance products, capacity and reinsurance products, that would provide SACCOs with competitive advantages. This chapter touches on several of these points, but more work is needed in this domain.

The partner-agent model: Challenges and opportunities

Michael J. McCord¹

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For as long as there has been insurance, there have been agents to sell it. The agents selling “industrial insurance” at factory gates in American cities in the early 1900s made the Metropolitan Life Insurance Company the largest company – not just insurance company – in the world at that time. Industrial insurance was essentially the forerunner of today’s commercial microinsurance. The transition from collecting premiums at the factory gates to group policies significantly enhanced the cost-effectiveness of the coverage. To reach the historic target market, employers became key players in bundling premium payments for the insurer, and ultimately even providing the coverage as an employee benefit. However, for today’s microinsurance target market, workers in the informal economy, group policies have to find a new delivery channel.

Such an option emerged when microfinance institutions began to identify insurable needs among their clients, since MFIs have financial transactions with large volumes of low-income people. Some MFIs turned to insurers, offering to act as intermediaries, and thus allowing their clients efficient access to insurance products. Seeing this as a low-risk, cost-effective way to enter a new market, insurers have also shown interest, at least in terms of basic products. Thus, the partner-agent model is simply a logical extension of a business model that has been used by insurers for the past century.

This chapter reviews the challenges and opportunities of using this agency model to deliver microinsurance to low-income households efficiently. In many ways, the partner-agent model is similar to the cooperative model discussed in the previous chapter, with a regulated insurer offering products through an institutional agent. The key difference is the ownership structure of the insurance companies. Credit unions own the insurer, while with the

¹ The experiences described in the chapter of Compartamos (Mexico), CARE and GLICO (Ghana), Constanta and Aldagi (Georgia), K-Rep (Kenya) and Kashf Foundation (Pakistan) are drawn from the author’s experiences, not from the case studies.

partner-agent model, the agents (frequently MFIs) are merely linked to the insurer in a contractual relationship.

The partner-agent model can be applied to different delivery channels. So far, it has most commonly been associated with MFIs, but more is being done to generate effective links with other channels such as retail shops, post offices, and even with prepaid phone cards. This chapter focuses generally on MFIs as agents and the experiences they have had with insurers. Chapter 4.6 describes partnerships between insurers and retailers as distribution agents.

1 Why a partner-agent model?

Critical components of successful microinsurance are efficient transactions and operations. If efficiency cannot be improved, the only way to reduce the premium costs to affordable levels is by reducing coverage. Providing a good product at an affordable price therefore requires efficient, yet controlled, processes. The key to efficient processes is the interface with the policyholder. This relationship defines the efficiency of sales, premium collection, information dissemination, and, in many cases, claims processing. The strength of the partner-agent model is that the agent, usually a microfinance institution, generally has an existing effective interface with the low-income market that can enhance efficiency.

Beginning as microcredit in the 1970s, microfinance became a global phenomenon in the 1990s once managers developed sufficient expertise to lend to the poor on a sustainable or profitable basis. Building on this firm foundation, managers began to express an interest in expanding their product lines. One particularly common scenario for MFI managers was to see a client do well for the first few loan cycles, only to then fall back into financial trouble. Research showed that when clients were having difficulty repaying their loans, it was often because of idiosyncratic financial risks such as a death or illness in the family. For organizations that used group-lending methodologies, a personal crisis affecting one member could undermine the cohesion of the group and contaminate the quality of several loans.

Several MFI managers recognized that insurance might reduce the impact of these problems. Some MFIs focused on protecting their portfolio through insurance; others also wanted to aid their clients and their families in difficult times. The decision then was to find a mechanism to insure their clients without distracting management and staff from their core products.

While some organizations decided to self-insure, for most, the choice was easy: turn to commercial insurers who already have mechanisms to address

these issues.² As many have found since, this model is usually the simplest, cheapest and quickest way for an MFI to start offering risk-management services outside traditional credit and savings products to its clients. As a bonus, this can be done with little additional risk for the MFI. An expanded product line, a source of fee-based income, protection for the MFI and its clients, little risk and virtually no financial input – how could it get any better?

Insurers in these arrangements get instant access to potentially tens, even hundreds of thousands of low-income policyholders, usually through a single group policy. Though some were reluctant at first, in many places insurers now actually compete to serve MFIs and their clients. Indeed, when Compartamos in Mexico was looking for an insurance partner, its three finalists were all major international insurers who fought hard for the business.

This model is also beneficial for low-income policyholders. They gain access to professionally-managed insurance products, to which they would otherwise have had very limited access. For clients of large MFIs, sheer numbers should allow the clients some control over product design, and the premiums should be more favourable. Finally, if there are disputes, the MFI is there to support them, rather than the low-income policyholders having to pursue the insurer to enforce the policy coverage.

This model clearly has the potential to be beneficial to all parties and can indeed provide a win-win-win situation. However, in many partnerships, there are still issues that need to be addressed to optimize the benefits for all parties, especially clients. Indeed, there are situations where clients could gain far more from this model, yet it is insurers and agents that are benefiting. The next sections will look at how the model is implemented and where some of the problems with it lie.

2 How the partner-agent model works

2.1 Selecting the partner

Unlike traditional agents, who are provided with a set of products developed by the insurer to sell to the unsuspecting public, MFIs have usually identified a need among their clients, translated that into a prototype insurance product, and approached insurers. The product concept often proposed to insurers includes a price range that clients would be willing to pay, and insurers are left to review the possibility of offering the product.

The bidding process used by CARE in Ghana (*as in Box 69*) has proved to be an effective way for an MFI to get the product that it wants under the

² See Chapter 4.7 for a summary of the advantages and disadvantages of self-insurance for MFIs.

most appropriate conditions. ASA in India also used the tender method, and sought insurers that would allow ASA to conduct the claims verification and pay clients directly, since the MFI had experienced significant problems with late and rejected claims with previous insurance partners. It sent out an invitation letter to a dozen insurance companies and received bids from almost all of them, perhaps because the letter said, in bold, “we have about 45,000 clients”. Interestingly, ASA chose to work with three insurers with nearly identical products, each covering a different geographical area. Although managing the three relationships involved more work, ASA preferred this solution because it created competition among the insurers. If one was underperforming, the MFI could seamlessly phase it out and transfer those clients to one of its other insurance partners.

Box 69**Selling an insurance concept in Ghana**

CARE conducted supply and demand research into offering microinsurance through rural banks in Ghana. It then brought all interested rural banks and insurers together for a one-day workshop to explain the results and the product concept itself. After this, CARE sent a tender offer out to all insurers. The interested insurers responded with their premium rates for the products demanded (as well as other specific requirements). CARE then used an assessment grid to select their ultimate choice – Gemini Life Insurance of Ghana (GLICO). The process generated much interest from the insurers – 12 insurers and brokers attended the original meeting and eight submitted responses to the tender offers – and certainly provided better results for CARE.

Source: Adapted from McCord, 2004.

Designing the product and the processes in this manner helped CARE and ASA obtain just what they wanted. Since their product concept directly reflected their clients’ needs, the clients were well served.

Many have argued that insurers will not accept a product concept that is developed by an institutional agent like an MFI. Certainly there are some insurers that are not interested in microfinance institutions or low-income clients, but these represent a minority. The experience of many MFIs has shown that if an insurance company is presented with compelling market research and an argument based on a sound understanding of insurance, then a specialized product will be accepted. Of course, the insurer evaluates and sets the premium, and may adjust the product to address specific institutional issues, but ultimately the product must respond to market demand as

represented by the agent. This is a common mode of operation for insurers working with insurance brokers.

2.2 Selecting the agent

Five years ago, the most common way for these relationships to emerge was for an MFI to approach insurers with a product concept. Today, however, some insurance companies are recognizing that this is a market that can be served, and they have proactively sought out potential delivery channels, including MFIs and other organizations that have financial transactions with the low-income market.

For insurers, finding an appropriate agent is also critical to success. Since the agent is the face of the product, its role in convincing prospective policyholders to purchase insurance is pivotal. Poor selection of agents can lead to serious delays in growth, bad public perception and dramatically higher costs.

Insurers want delivery channels with many clients, potential for growth, a strong reputation for customer satisfaction and a commitment to insurance at the board and management levels. Partnerships are more successful if the agent has a computerized MIS and a strong training function. Certainly, insurers are happiest when they can offer group products through one master policy for the institutional agent such as an MFI, a labour union or other large group of low-income people, and when the product is mandatory.

When initiating the search for an appropriate agent, the insurer must remember that its own ability to recognize poor households as a separate market requiring distinct products is crucial to success. Insurers need to be willing to alter their standard products – or better still, develop new products from scratch – to suit the characteristics of the low-income market.

In some jurisdictions, insurance agents need to be licensed; in some cases, agents cannot be organizations, but must be individuals. The licensing process may involve a certain number of hours of training and/or passing an exam. These requirements are often not conducive to officially registering an MFI or selected staff members as agents, and therefore an appropriate means of complying with insurance regulations needs to be explored (*see Chapter 5.2*).

2.3 Clarifying roles

Once the product concept is developed, and the insurer and agent have identified each other, it is important that the parties identify the roles they will play in the microinsurance process. Formal agreements or **memorandums of understanding** (MOUs) will minimize future disagreements, foster a

smoother working relationship and form the foundation for governing relationships.

In developing the agreement, each party must understand the various components of insurance delivery and agree on where the responsibilities lie. Some of the elements clearly fall to one party or the other. Regulatory reporting lies with the insurer, just as premium collection lies with the agent MFI. Other elements might not be as clear. Key responsibilities that must be addressed within an agreement are described below.³

Underwriting

To maximize the efficiencies of this model, underwriting is typically carried out in the course of the claims verification process. In this case, a sort of underwriting takes place simply by virtue of a policyholder's ability to conform to the policies and requirements of the organization through which it purchases the insurance. For example, AIG Uganda takes every policyholder provided by the MFIs. There are no restrictions to entry other than the ability of a person to join one of the many MFIs in Uganda. One of the main advantages for insurers to collaborate with an MFI, as opposed to an organization that does not lend, is that its credit screening can be a substitute for life insurance underwriting. Chapter 3.4 discusses in more detail the importance of shifting underwriting from the initial application phase to the claims end of the process.

Staff training

Generally, the agent's frontline staff members require training in insurance principles, insurance marketing and the details of the particular product. This training can be provided directly by the insurer. Alternatively, the insurer can help develop the training materials for the MFI's training staff to deliver. La Equidad in Colombia, for example, has developed a special programme to train the credit analysts of its agent Women's World Foundation (WWF). WWF invests an average of two days on insurance out of 45 days of training for new credit analysts using the programme designed by La Equidad. Other staff need training and guidance on such issues as scheme administration and MIS applications.

Premium collection and remittance

As highlighted in Box 70, the premium collection process is extremely detailed. This process must be documented so that each party is clear on the

³ A comprehensive list of insurance activities that should be part of a partner-agent agreement can be found in Churchill et al., 2003.

timing and its role in the process. Efficiency is critical. Since MFIs already have financial transactions with their clients, it is relatively easy for them to collect premiums as part of loan payments or from policyholder savings.

Box 70

Partner-agent premium collection checklist

- When do clients pay the premium?
- When does the agent remit the funds?
- Are the premiums remitted in cash?
- Can the agent use the premiums to pay claims?
- Is the commission deducted from the premiums?
- What information does the insurer require as support for each premium payment?
- Where is that information kept?
- In the absence of national identification numbers, how does the insurer wish to designate the insured?
- Does the policy come into effect when the agent collects the premium payment?

The exchange of policyholder information relating to premium payments must also be carefully assessed. What information is really needed by the insurer relating to premium payments? AIG Uganda, for example, requires MFIs to pay aggregate premiums on a monthly basis – which is efficient – but the payment must be accompanied by a physical list of all those covered under the group policy. One MFI submitted close to a ream of paper each month to satisfy this requirement. This process requires significant effort, supplies and even storage space. It is clearly not efficient.

Alternatively, Aldagi in Georgia, with its MFI agent Constanta Foundation, uses an electronic system that downloads relevant data automatically on a daily basis. There is virtually no human intervention in this process. Other MFIs with savings capabilities, like K-Rep Bank in Kenya and the rural banks of Ghana, require the insurer to retain the premiums in an account in their banks. This simple arrangement assists the microfinance banks with liquidity management.

Any partner-agent agreement should ensure that as much as possible is done electronically. The use of computers and electronic communications is an important way to reduce the cost and effort of managing microinsurance, as well as of collecting the necessary client demographic data.

Claims processing

Since timely claims payment is critical to the credibility of the institutions (not to mention to the needs of the beneficiaries), an agreement on **service standards** is imperative. In some of the early experiences with the partner-agent model, insurers generally insisted that they pay claims, but often with very poor results. In ASA's experiences with Life Insurance Corporation of India (LIC), claims regularly took three months or more to be paid, and even then a number were rejected because they were unable to prove the age of the deceased (some were never issued with a birth certificate) or because some of the required documentation used a nickname rather than the official name. Some microinsurers had a backlog of claims, with some stretching beyond a year. This is unacceptable for any microinsurance programme.

To avoid these problems, many MFIs such as ASA and Kashf in Pakistan decided to settle claims directly. This can be a sensitive issue for insurers, but where it is done, beneficiaries profit from the practice. Common among the affiliates of Opportunity International, Leftley (2005) refers to this approach as an amended agency agreement. The MFI verifies that the claim is valid and, if so, pays the claim from the premiums collected but not yet submitted to the insurer. At the end of the month, the MFI submits the net premium schedule showing the total premium collected and the total claims paid, along with all claims documentation. In the event that the insurer identifies a claim that was paid in error, then the MFI is responsible for refunding the insurance company. This issue is further described in Chapter 4.5.

If the insurer insists on paying the claims, an innovative alternative has been a settlement guarantee, whereby the insurer agrees that claims (with proper documentation presented) will be settled within two weeks or it will pay a bonus of, for example, 25 per cent. This reduces the liability of the MFI and creates an incentive for the insurer to perform efficiently. Clearly, the extra step of getting documents to the insurer for payment back through the MFI is time-consuming, and those that pay directly have an advantage with their clients as long as controls are simple, clear and effective.

While it may be possible for the MFI to pay claims for life insurance, it is more difficult for other types of cover. Even making the distinction between natural and accidental death may be difficult for the MFI's field staff. Health insurance is even more complicated. Among a variety of other controls, VimoSEWA (India) and UMSGF (Guinea) employ doctors to participate in claims committees to assess whether clinics are providing the correct treatment and following approved protocols. Generally, health insurance claims are too onerous for agents to manage.

With a different approach to claims verification, United India Insurance Company (UIIC) worked with Shepherd, a microfinance NGO, to create a review committee to address microinsurance implementation issues and decide upon questionable claims. This committee is composed of two representatives from UIIC, two from the policyholders, and one from Shepherd. The committee permits effective responses to claims issues and supervision of product implementation, as well as enhancing the overall control of the programme.

2.4

Implementation

As with other aspects of microinsurance delivery, efficiency in implementation is critical –and this is where a partner-agent relationship can prove its worth. In principle, the MFI's staff frequently interact with their clients. The opportunities to cross-sell insurance are thus frequent and the incremental cost of this should be almost negligible. The idea is to use existing networks and relations of an MFI agent to add another product, which theoretically should lower acquisition and transaction costs, especially when compared to using specialized insurance agents to sell individual products.

Yet the theory of implementation has not matched the reality of dealing with MFIs. The simple cross-selling approach has not been successful in many institutions, primarily because microinsurance is not the agents' core business. Typically, savings and credit are the core business of an MFI. Insurance may support the core business, for example by mitigating the credit risk of the agent as well as its clients, but when delinquency problems arise, there is little effort to market insurance. As the loan portfolio is the key asset and income generator for most MFIs, it is logical that when it is threatened, the attention of management and staff will shift to address this problem. This point is true of other delivery channels also and illustrates an important hurdle for advancing microinsurance. Offering microinsurance efficiently through other organizations will always result in second class treatment for such products compared to the delivery channel's core business.

Even when things are going well, some potential microinsurance agents have no interest in insurance because core business growth takes up all available resources. ProCredit Bank in the Ukraine, for example, was marginally interested in microinsurance and began testing a partnership with a local insurance company. Before the test was even concluded, it became clear that, due to phenomenal growth in its core business, management would not divert its attention to a non-core product.

The expectation that microinsurance could be seamlessly implemented into an MFI with essentially no additional cost has proved overly optimistic. Several institutions have recognized the need to have someone within the agent institution to liaise between the insurer and the MFI. In some cases, the agent allocates someone to manage the relationship from its side, to oversee training, manage the reporting and communications with the insurers, answer questions from staff and generally act as the insurance product manager. In some cases, as with GLICO, the insurer will actually place one of its agents with the MFI to ensure proper sales and service.

The expectation that an MFI's staff will cross-sell insurance has generally not been satisfied either. Demand and customer satisfaction studies have shown that microfinance clients often have little understanding of the insurance products they have purchased. This is especially true of mandatory products. When a product is mandatory, field staff see little reason to promote or even discuss the microinsurance product.

Commitment to keeping clients knowledgeable and informed is necessary for success in microinsurance. Without such a commitment, policyholders only see insurance as an additional cost to borrowing for mandatory products and voluntary products are likely to experience low renewal rates.

2.5 Financial arrangements with the agent

Although MFI agents have generally limited their microinsurance offerings to products that directly relate to their loan portfolio protection needs, they also rightly expect a direct financial benefit from selling insurance for an insurer. Three remuneration methods were identified in the case studies:

1. Commissions paid to the agent as a percentage of the premiums collected
2. Profit sharing with variable income/loss potential
3. Premium mark-ups where the MFI agent adds an additional amount to the premium charged by the insurer

Commission-based remuneration

The most common way for MFI agents to earn income from insurance is through commissions, which typically range from 5 to 20 per cent of premiums paid. Some of the more professional MFI agents track the costs of selling and servicing microinsurance products. It is critical for the agent to understand its insurance-related cost structure and to ascertain if it is at least breaking even on the activity. Some MFI managers argue that, because the activities are added to the existing infrastructure and delivered concurrently with credit or savings products, insurance effectively generates no additional cost.

However, without a costing analysis, agents are never sure of the product's profitability.

Using activity-based costing (ABC), ASA assessed the cost associated with the sales and service of its insurance products and determined that the administrative cost per policy per annum is US\$1.80 (see Table 38).

Table 38 ASA's cost per policy (January 2005)

Category	Annual expense (Rs.)	Annual expense (US\$)
Staff costs	1 500 000	33 333
Non-staff costs (e.g. stationery, rent, computers)	1 460 000	32 445
Branch incentive fee	1 325 250	29 450
Total annual costs for all policies	4 285 250	95 228
Total number of policies sold	53 010	
Total servicing cost per member	80.84	1.80

Source: Roth et al., 2005.

Table 39 assesses the profitability of its microinsurance activities on the basis of the cost per policy. The premium per policy is consistent at Rs.125 (US\$2.78), but the premium retained is different for Max New York. When the cost per policy is compared to the premium retained per policy (column B), it is clear that there is a profit with the first two insurers and a loss with the third.

When this costing was carried out, ASA's administrative costs were 64.6 per cent of premiums and profits were 4.8 per cent of premiums.⁴ (Additional administrative costs must also be applied against the balance that was paid to the insurer.) By tracking costs and incomes in this way, an agent is better able to manage the level of costs, and in this case it is clear that there is a need to identify potential additional efficiencies to reduce the very high administrative costs.

⁴ The weighted average cost per policy is Rs. 86.8, or 69.4 per cent of premium. Administrative cost to premiums is $80.84/125 = 64.6$ per cent, and profit is $(86.8-80.84)/125 = 4.8$ per cent.

Table 39 ASA's profit/loss per policy (January 2005)

<i>Insurance company</i>	<i>A) Premium received from the client</i>	<i>B) Premium retained to cover expenses</i>	<i>C) Profit or loss per policy (Column B-Rs. 80.84)</i>	<i>D) No. of policies</i>	<i>E) Profit or loss on all policies (Rs.)</i>	<i>F) Profit or loss on all policies (US\$)</i>
AMP-Sanmar	125	89	8.16	26 444	215 822	4 796
Allianz Bajaj	125	89	8.16	18 218	148 686	3 304
Max New York	125	75	-5.84	8 348	-48 740	-1 083
Totals				53 010	315 768	7 017

Source: Roth et al., 2005.

Table 40 Performance of four microinsurance schemes in Zambia

	2004			
	<i>Pulse Holdings</i>	<i>PRIDE Zambia</i>	<i>FINCA Zambia</i>	<i>CETZAM</i>
Premium value (US\$)	25 345	28 098	31 826	17 507
Claims (US\$)	12 252	5 034	3 302	1 613
Claims ratio (%)	48.3	17.9	10.4	9.2
Net premiums (US\$)	13 092	23 063	28 534	15 894
Profit sharing (US\$)	4 582			
Profit sharing (%)	18.0			
Admin fee (10%)		2 810	3 184	1 751
	2003			
Premium value (US\$)	18 603	4 010	9 571	7 544
Claims (US\$)	9 803	786	976	3 749
Claims ratio (%)	52.7	19.6	10.2	49.7
Net premiums (US\$)	8 800	3 224	8 595	3 794
Profit sharing (US\$)	3 080			
Profit sharing (%)	16.6			
Admin fee (10%)		401	957	754

Source: Manje, 2005.

Profit-sharing

The second remuneration approach, profit-sharing, is a means of sharing the risks and profits to generate a potentially greater income (or loss) for the MFI agent. This method places some of the risk of insurance with the institutional agent. Typically, this potential liability is capped at the amount of premiums paid, so the MFI agent might possibly lose its investment in the costs of selling and servicing the products, but any additional loss is borne by the insurer.

Madison Insurance works with four institutional agents in Zambia. Three are paid a guaranteed commission of 10 per cent of premiums, while the fourth, Pulse Holdings, is paid on a profit- (and risk-) sharing basis. Table 40 shows some key results from the four MFIs.

In this case, the profit-sharing arrangement calls for Madison to pay the claims from the premium pool and then retain 35 per cent of the net premiums (after claims) to cover its costs. Any balance is then shared equally between the insurer and the MFI. This arrangement provided a greater return for Pulse Holdings over the two years – 16.6 per cent for 2003 and 18 per cent for 2004 – than the guaranteed 10 per cent return for the others, even though Pulse had a dramatically higher claims ratio. It is important to recognize that with a profit- and risk-sharing mechanism, the return could be zero. However, it appears that Pulse, and Madison itself, are protected by excessively high premiums. The claims ratio for Pulse in 2005, for example, would have had to be over 70 per cent for Pulse to make only the 10 per cent that the others earned. With the average aggregate claims ratio for the commission-based agents at only 16 per cent, it is clear that this product is seriously over-priced.⁵

Premium mark-ups

The third option is premium mark-ups, such as those used by many MFIs in Uganda which impose a surcharge of up to 100 per cent on the premium. In other words, if the insurance cover costs 0.5 per cent of the loan amount, the MFI charges 1 per cent and keeps the other 0.5 per cent. In the case of AIG Uganda, the insurer does not pay any commission to the MFIs, but it does pay a 20 per cent commission to its own insurance agent. This results in an unconscionable level of administrative costs and premium levels, which are multiples of what would be reasonable. Additionally, it is likely that such mark-ups are illegal in countries where the insurance authorities officially approve premiums.

⁵ Note that with an aggregate claims ratio of 16 per cent plus the 10 per cent administration fee paid to the MFIs, Madison has 74 per cent of premiums to split between 1) the very low administrative costs of its operations related to these products, 2) probably no reinsurance costs and 3) profits which are likely to be between 50 per cent and 60 per cent of premiums.

In the Philippines, Opportunity International steered its MFI affiliates towards this mark-up approach after it learned that it was common practice to increase the premium rate significantly if a commission is paid to the intermediary. For example, if a 20 per cent commission is required to cover the MFI's costs, then it is common for the net rate without commission to be increased by over 100 per cent. On the basis of this observation, it was agreed that MFIs would pay the net rate to the insurer and receive no commission, but would instead load the rate charged to the clients with an administration fee. This resulted in a cheaper end-solution for the organizations' clients.

2.6 Conclusion

In implementing the partner-agent model, there are several areas of concern that should be worked out before the product is offered to potential policyholders. Each party must understand its role, and the roles should be allocated on the basis of where each institution's comparative advantage lies. In developing the product and negotiating with the insurer, the MFI agent has a dual role: it must ensure that its own institutional requirements are met in terms of distribution, cost cover, and capacity requirements, but it must at the same time represent its clients and their needs. In some cases, especially in Asia, MFIs have done commendable work in representing their clients' needs and negotiating products that respond to those needs. In most cases however, MFIs appear too focused on their portfolios and on generating significant earnings, resulting in products that neither reflect their clients' needs, nor offer them real value.

3 The good and the bad

The partner-agent model has not been for everyone. Many find that it fits their needs. Some, like VimaSEWA and ASA, began with the partner-agent model, moved to self-insurance, and then back to the partner-agent model. As described in Box 71, ASA is finally firmly committed to the partner-agent model now that it is better able to manage the relationship with insurers and can influence the design of the products.

Box 71

ASA's on-again off-again on-again relationship with the partner-agent model

ASA has flip-flopped between the partner-agent and full service models several times over the years, sometimes even combining the two (e.g. carrying the risk of natural death in-house, but outsourcing accidental death cover to an insurer). However, it now appears firmly committed to collaborating with

insurance companies. Part of this commitment is due to its experience; it recognizes the risks of in-house insurance without reinsurance. Another factor is that ASA has had sufficient experience with insurance partners for it to know now what to ask for and how to manage the relationship – and with 45,000 borrowers, it has the volumes to be demanding. As a result, ASA has designed its own product to meet its needs and generate a little income, while someone else takes the risk.

Source: Adapted from Roth et al., 2005.

Insurers working with MFI agents have experienced mixed success with this model. Penetration has been relatively low with voluntary products, although some agents are more successful in distributing insurance than others. Some of the factors correlated with sales success include:

- **The size of agent’s client base** – Agents with more clients tend to experience better penetration rates than smaller ones.
- **Management attitudes** – Agents that are more successful appreciate the strategic nature of insurance in their product offering and demonstrate appropriate management disciplines such as setting sales targets.
- **Employee attitudes** – The attitude of the field staff to insurance is a critical factor in achieving positive sales results. If they are not enthusiastic about the product, it is difficult to achieve sales success.

Although insurers typically want to “offer” **compulsory insurance**, this only makes sense when there is a direct relationship between the product and its compulsory nature. For example, an MFI can link credit life cover to a working capital loan or home insurance to a housing loan. When insurers offer products that reach beyond the direct link, they must be voluntary, and therefore must be actively sold by the intermediary. This has proved difficult.

As it is currently conceived, this model is limited to the depositors or more probably the borrowers of an MFI. Yet there are few places where microfinance institutions work with even 10 per cent of the potential market. In a country like India, where insurance regulations require insurers to serve the low-income market, Tata-AIG found the partner-agent model too restrictive. Too many microfinance institutions already had relationships with other insurers, and the penetration of MFIs in India was low compared to the potential market. Thus, Tata-AIG developed its own model using NGOs to identify local people to become “micro-agents” (see *Chapter 4.6*). The saturation of MFIs willing and able to work with insurers in India coupled with the relatively limited outreach of MFIs is an important considera-

tion for the partner-agent model, and will continue to push insurers into identifying and working with non-MFI delivery channels.

Delta Life experienced similar challenges when it tried to offer insurance through a microfinance NGO in Bangladesh. Part of the problem lies with the type of product that Delta and Tata-AIG offer. Microfinance institutions are not particularly effective distributors of **endowment policies** for two reasons. MFIs typically tie their policies to loan products. Endowments require long-term, consistent transactions. MFI credit is usually short-term with occasional non-borrowing gaps. There is limited compatibility between these two approaches. Also, for MFIs that accept savings, endowment products compete for the limited resources of the low-income client.

Chapter 1.2 describes the demand for microinsurance from the low-income market and shows that in most countries the greatest need for risk-management assistance, and indeed the greatest need for insurance, is in the area of health cover. Initially, it was thought by some that **health insurance** would come as part of an evolutionary process. If insurers could be enticed into entering the market for life and other basic products, they could be gradually encouraged to move to more complicated ones, including health. Except for a few notable cases – such as VimoSEWA and Shepherd, both in India – this evolution has not taken place. The reason for this is both a general reluctance by the insurers and a lack of pressure for evolution by the MFI agents, who are also supposed to represent their clients. Since health insurance cannot be provided as a mandatory product in most places and the products do not relate directly to repayment of loans, this has hindered development of health cover through this model.

4 Advantages and disadvantages

In the partner-agent model, there are three key actors – insurers, MFIs or similar agents, and the low-income people ultimately covered by these policies. Although billed as a win-win-win approach, in practice the model has shown advantages and disadvantages for each of these groups.

4.1 The agents

For MFIs, it is easier to offer insurance in partnership with a formal insurer than to start their own insurance company or to insure on their own (*as shown in Table 41*). The ability to offer insurance without the requirements of knowledge, funds or regulations makes this an easy option.

The disadvantages generally relate to relationship issues. MFIs and insurers enter into negotiations with vastly different knowledge bases. The insurer knows insurance while the MFI knows the market. What makes this an ideal relationship – the merger of two skill sets – also creates the potential for abuse. Although both insurance knowledge and market access are key inputs, too frequently MFIs defer to the insurer’s expertise while failing to convey their market knowledge to the insurer. This is a mistake. Where MFIs are able to influence product design, or where there is insurer competition, there are clearly better products for clients at better terms.

Table 41

Advantages and disadvantages to the agent compared to self-insuring

<i>Advantages</i>	<i>Disadvantages</i>
1. Often the simplest, cheapest and quickest way to start offering insurance	1. Need to negotiate with a third party for a product that meets clients’ and the MFI’s needs
2. Lower financial and reputation risk	2. Income often restricted to commissions; low risk, but also relatively low reward
3. Guaranteed income from commissions, or potential income/loss from profit-sharing	3. Service standards may be in the hands of a third party (if the insurer is paying claims)
4. No capital requirements	4. Field staff have additional, non-core business responsibilities
5. Few or no regulatory requirements	5. Need to create an incentive structure to motivate staff to sell the product or at least keep clients knowledgeable about the products
6. No need for expensive specialist managers and staff	6. Potential limitations on product design and benefits due to restrictions on what the insurer will, or legally can, cover
7. Can offer products that are safer for clients	

For the partner-agent model to work for MFIs, a number of requirements must be satisfied:

- MFIs must use the size of their market to get what they want in products and terms. They must press insurers to offer products that respond better to the needs and demands of their clients, and push for continued product evolution to respond better to advanced client needs.
- There must be competition among insurers in the form either of a number of insurers selling to the MFI or of tender offers and annual policy reviews.
- There must be better integration of microinsurance in the front office, so that field staff appreciate the value of insurance to their clients and receive incentives to sell voluntary products and inform clients about mandatory products.

- The value of a range of insurance products for the MFI’s clients, and indirectly for the MFI must be recognized. This will provide an incentive for MFIs to compel insurers to offer the products and to sell them in a professional manner to their clients.

4.2 The insurers

The advantages of this model for insurers are easy to identify. The disadvantages are relationship-based, as shown in Table 42. MFIs generally have made disappointing agents. They have been weak at marketing and the potential of the market they provide access to is rarely achieved with the insurance products offered.

Table 42

Advantages and disadvantages for an insurer

<i>Advantages</i>	<i>Disadvantages</i>
1. Simplest, cheapest and quickest way to enter the low-income market; the agent gives the insurer instant credibility with a sceptical market, large volumes of clients and an efficient transaction mechanism	1. Working with agents with limited knowledge of insurance
2. Improves risk diversification by adding substantial numbers of policyholders, especially with a mandatory product	2. Significant upfront effort in training MFI staff, and developing processes and marketing materials
3. Positive impact on corporate social responsibility requirements and relations with regulators	3. Reliant on the agent who could change its view of the insurer’s products or services after the initial investment
4. Improved understanding of risks through agents’ historical data on clients	4. Risk of losing a substantial portion of business should the agent shift to another insurer, or shift priorities
5. The product prototype should be developed from market research conducted by the agent	5. Service standards are in the hands of the agent leading to potential reputation risk
	6. Must adapt controls to manage special products

For the partner-agent model to work for insurers, they must:

- Take an active role in training and motivating the frontline agent staff (in coordination with the institutional agent). Some insurers have staff responsible for these accounts and their interactions must improve to make the agent’s staff more effective.
- Recognize that insurance will never be the primary focus of any institutional agent and thus focus on making each process simple to offer, simple to manage, and simple to transact. If the product is simple in every way, the effort

required by the agent will be reduced, and there is greater potential for sales to be improved.

- Make sure policyholders are receiving correct information. This will improve the potential for renewals.
- Although the theory is that there would be limited intervention on the part of the insurer, it is clear from these case studies that insurers must have a stronger role in guiding the process.

4.3

The clients

Potential policyholders are at the mercy of their agents and the insurers. Access to regulated insurance products should be beneficial, but in many cases has not only proved unhelpful, but actually detrimental, at least in terms of paying unnecessarily high premiums for unsatisfactory products. This may have been justified initially as insurers took a conservative approach while they tried to understand the risk in this market. As significant data is now available, premiums should be falling, but they are not. Much of the problem relates to policyholders' reliance on two entities to represent them – the institutional agent and insurers, both motivated by profit. Advantages and disadvantages of the partner-agent model for the low-income market are summarized in Table 43.

Table 43

Advantages and disadvantages for low-income policyholders

<i>Advantages</i>	<i>Disadvantages</i>
<ol style="list-style-type: none"> 1. Gain access to products through regulated insurers that they would not have had otherwise 2. They should be able to take advantage of pool pricing 3. The insurer is backed up by reserves, legislation, and when appropriate, reinsurance so there should be virtually no risk of insurer failure 4. Have the potential to access a broad range of products 	<ol style="list-style-type: none"> 1. Their representative (frequently the MFI agent) has a conflicting role in negotiations, representing both its own objectives of profit maximization and those of value for money for its clients; often products are designed for the benefit of the agent 2. When there is conflict, clients are reluctant to confront their lender for fear that this may adversely affect their borrowing capacity 3. Too frequently low-income people can only obtain insurance if they are borrowing, and borrowing is not always necessary for the client 4. Premiums in most cases remain too high, as illustrated by the minimal level of claims to premiums observed in many programmes

For the partner-agent model to work for the low-income market:

- their clients' needs and demands must be the basis for products and how they are offered;
- regulators must allow simplicity in policies and procedures while protecting the rights of this market;
- MFIs must develop ways to include clients in their product development and review procedures, and then apply the information in their negotiations.

5 Conclusions

The partner-agent approach is still evolving. Over the last several years, insurers have become more interested in the low-income market; MFIs and similar agents have become more adept at structuring deals that best match their needs, and sometimes even the needs of their clients. There is still reluctance from insurers to offer health products, though this is changing. The initial reluctance to provide even life insurance has diminished to the point where insurers are seeking MFIs and other partners through which to access the low-income market. MFIs have a limited share of the low-income financial markets around the world. Now that insurers see the potential of microinsurance, they are actively searching for alternative and complementary delivery channels (*see Chapter 4.6*). It is clear from these cases that massive outreach will require new and efficient delivery channels.

On an institutional level, it was expected that premiums would initially be high, but that after a year or two of experience, the rates would fall and product ranges would expand. There should also have been a corresponding reduction in the net earnings of the insurers. Indeed, this has occurred with some of the insurers, though others are earning excessive returns. The controls on these profits must come from the MFIs and others that sell products to low-income clients.

There is market pressure to manage these premiums in ways that benefit the clients. AIG Uganda, which had a monopoly in this market until recently, has found itself struggling against two new competitors. This is the market in action. Competition in microinsurance will lead to better products and more appropriate premiums for low-income consumers. The forerunners of this model may not have had, and may still not have, products or premiums that truly respond to the needs and demands of this market. However, they have blazed a trail, and the newcomers will generate competition to improve insurance for the poor.

The partner-agent model currently seems to work best when:

- insurance is directly related to the products of the agent institution;
- the MFI agent has sufficient knowledge and motivation to actually represent its clients in negotiations with insurers and manage the product development process;
- the MFI agent recognizes the benefit of insurance not only in protecting the MFI's portfolio, but more importantly for its clients;
- products are simple in all respects, from the initial entry requirements to a policy with a minimum of exclusions, and a settlement process that makes it easy to submit valid claims;
- the products are valued by the MFI's clients, and are mandatory;
- premiums are fair for all concerned;
- the agent's field staff are sufficiently skilled and actually take the time to explain insurance and the product clients are buying;
- for the low-income market, the insurer develops a different business model from that used for its traditional clientele.

The partner-agent model has significant potential. It is still early in its evolution, progressing slowly on the basis of lessons learned. The flaws in the model can be addressed relatively easily through training and capacity-building of both the risk carriers and delivery channels. However, insurers would be wise not to put all their eggs in the MFI basket. These case studies have shown that massive expansion of microinsurance will require a broad range of delivery channels and that working with MFIs alone will not be sufficient.

4.3

The community-based model: Mutual health organizations in Africa

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This chapter deals with a specific microinsurance model, the community-based model, in a specific region, Africa. It also deals with a specific field – health insurance – which is certainly not the easiest type of insurance to offer (see *Chapter 2.1*). Considering that access to healthcare remains a major unresolved issue in Africa, health microinsurance systems are one of the ways to solve this problem, at least partially.

Community-based health insurance is not a theoretical model. It has been a pioneering approach to extending social protection since its development began more than 15 years ago. Based on several studies² and on the experience of external support organizations active in this field (particularly the ILO's STEP programme and the French NGO CIDR), this chapter explains past and current developments in this specific model.

This chapter is divided into six sections. The first section describes a specific community-based model, the mutual health organization (MHO) and its theoretical application in West Africa. The second section provides information on the proliferation of this model in West Africa while few other approaches have been tested in the region. Section 3 briefly examines the target group of MHOs in West Africa. The next section explores strategic questions, namely: do the mutual health organizations function (well) and are they having an impact? To explain some observations made in this fourth section, section 5 examines the specific origins of the problems described. Finally, the last section illustrates the intrinsic added value of the community-based model.

¹ The references to Alliance Santé in Benin are drawn from the authors' experiences, not from the case studies.

² For example, see Atim, 1998, Atim et al., 2005, Fonteneau, 2004, Fonteneau et al., 2004, Jütting, 2002 and Tabor, 2005.

I What is a community-based model?

It is difficult to give a standard definition of community-based microinsurance. Literature on the subject has almost as many definitions of the model as there are community-based organizations (CBOs) or specialists. In practice, various insurance schemes containing some community-based elements have been experimented with throughout the world. Uganda has tried several systems governed and managed by hospitals involving community groups in the design of benefit packages and collection of premiums (Dierrennic et al., 2005). Tanzania is implementing a nationwide system called the Community Health Fund (CHF). Members are organized in management committees, which include the healthcare managers, although the rules of the CHF (including the premium amount) are fixed by district authorities (Musau, 1999). Another way of managing health microinsurance is through MFIs. If an MFI is community based, which is to say organized as a mutual like AssEF in Benin, its microinsurance scheme could be included in the community-based model.

A few NGOs have experimented with health microinsurance managed by professionals, which shares the objectives and features of a community-based model. For example, in the SKY programme launched by the French NGO GRET in Cambodia, professionals employed by the NGO manage the scheme. Clients in village committees are regularly consulted to ensure that the scheme is accountable to the policyholders (CIDR, 2005).

Notwithstanding this variety of community-based insurance schemes, this chapter focuses on one particular type: the mutual health organization or *mutuelle de santé*. The main geographical reference is West Africa because this model is most common in this region (Tabor, 2005).³

Mutual health organizations were originally developed in Europe in the 19th century where workers' organizations set up mutual funds to improve access to healthcare in the absence of other kinds of social protection. In several countries, these initiatives have contributed significantly to the implementation of a social protection policy at the national level.

I.1 Essential features

The essential features of MHOs demonstrate their strong community-based nature and reflect the purposes and operations of the model:

³ Some examples provided by CIDR come from other African countries since CIDR is one of the only external support organizations implementing MHOs elsewhere on the continent.

- Improve access to healthcare through risk-sharing and resource-pooling
- Not-for-profit
- Mutual-interest organizations based on groups sharing common characteristics
- Members are owners and beneficiaries at the same time
- Participatory decision-making
- Voluntary membership
- Promotion of solidarity, democracy and social cohesion
- Potential functions beyond insurance

Like other insurance systems, mutual health organizations are based on a mechanism of risk-sharing and resource-pooling. However, more specifically, these organizations are non-profit and do not select their members on the basis of their individual risk profiles. Access to healthcare through solidarity is thus the main objective of these organizations.

The members of mutual health organizations are the owners, the decision-makers and the policyholders, which strongly differentiates this model from other insurance schemes. This feature requires strong participation and control mechanisms to make collective decision-making effective. Annual general meetings decide on issues such as budgets, accounts, what to do with surpluses, and operational matters as well as overall strategy. Members govern their MHOs through elected representatives, who are responsible for implementing control mechanisms, such as monitoring the implementation of internal rules, controlling financial flows and collecting complaints relating to the service provided.

Membership is voluntary. This principle clearly distinguishes MHOs from compulsory insurance schemes such as most national and often state-run social security systems. As in any non-profit organization, a person may choose to become a member but is never forced to join.

In most MHOs, members share some common characteristics, such as being members of the same organizations, inhabitants of the same village or workers in the same trade, often because they are built on an existing organization (*see Box 72*). Bearing in mind that membership is voluntary, an MHO has to find a way of ensuring that it can gather a “sufficient” number of members to run the risk-sharing mechanisms in an efficient and attractive way: the larger the group, the greater the benefits for the members. Being organized in a (formal or informal) pre-existing group facilitates this process. In addition, sharing some characteristics, or better, being previously involved in similar collective decision-making mechanisms with the same group, facilitates the functioning of an MHO.

Box 72

Profiles of initiating organizations of MHOs

In Burkina Faso, the Association *Yekouma Dakoupa* and the Association of Widows and Orphans from the Leere (*Association des Veuves et Orphelins du Leere*) offer a range of services such as agricultural support, microcredit and school fees for orphan children. A group of women organized an informal solidarity fund to help members and their families when facing a health event. Worried that this fund would not be sufficient to cover all needs and health expenses, they decided to set up a more sustainable system. They contacted the STEP programme with whom they set up a mutual health organization called Leere Laafi Bolem in 2001.

In the case of the *Lalane Diassap* MHO in Senegal, a village youths' organization (*Association des Jeunes de Lalane*) took the initiative to launch a village-based mutual health organization in the mid-nineties. Staff already working with other mutual health organizations in the Thiès Region helped to launch this initiative.

In the case of the *Mutuelle de Fatako* (Guinea Conakry), a women's association (*Association des Femmes Ressortissantes de Fatako*) identified access to healthcare as a major problem for Fatako inhabitants. Together with the STEP Programme and the *Association Guinéenne de Bien-Etre Familial* (ASBEF), they created a mutual health organization in 2002.

Source: Adapted from Fonteneau et al., 2004 and Fonteneau, 2004.

MHOs actively promote some ideals like solidarity, democracy or social cohesion. These values are particularly important for the resource-pooling and risk-sharing of microinsurance, since members' familiarity with each other can assist in controlling moral hazard and fraud, and can encourage renewals.

However, unlike other insurance providers, an MHO cannot be reduced to its insurance function. As participatory, mutual-interest organizations, MHOs fulfil functions beyond insurance. For instance, the MHOs objectives almost always include health education. They also act in a sector (healthcare) where the interests of users have only recently been represented. By organizing potential users of health services, MHOs can represent their interests to healthcare providers. In the same way, since the state is a key actor in healthcare systems, MHOs can represent the population in policy discussions. For example, these community-based organizations may lobby on health financing issues and participate in social protection reform processes (see Chapter 1.3).

1.2 Consequential features

Apart from these essential features, other characteristics are also worth mentioning to provide a more complete picture of the MHO model. These features are “consequential” in the sense that they result from the model, but are not inherent characteristics.

The setting-up of an MHO often implies the creation of a new organization even when an existing organization takes the initiative to start a micro-insurance scheme. In other models, insurance can indeed be developed as a product offered and managed by an existing institution (e.g. MFIs or insurance companies). In the case of an MHO, the insurance scheme is the organization. The new organization created for the purpose of providing insurance leads to an institutionalization process that requires extra effort from the initiating organizations and/or from external support providers.

The MHO schemes are managed and controlled by members who financially contribute to them. This does not mean that an MHO has to be self-managed, but in reality this is often the case. Managers, who are members themselves, are elected or designated by the members of the insurance schemes. They often fulfil this function on a voluntary and unpaid basis. Voluntary “self-management” is one way to ensure continuity between the members and the institutions, and avoid conflicts between the management and the beneficiaries. However, voluntary, unpaid jobs are also chosen out of necessity due to the lack of resources. This practice reduces the costs of the insurance product, but is not a long-term solution.

As mentioned earlier, microinsurance schemes consist of members sharing some common characteristics. This feature ensures the necessary minimum level of trust and social cohesion to set up and run an MHO according to the features described (i.e. self-management, a collective decision-making process, participatory mechanisms, risk-sharing). Especially in the beginning, the membership of an MHO is often homogenous, which can have negative effects due to a lack of risk diversification. Such a situation also has a limited ability to achieve vertical solidarity, which allows for cross-subsidization between richer and poorer people.

2 Why was/is this approach implemented in West Africa?

The existence and implementation of MHOs in Africa did not occur by chance. African MHOs first appeared in the late 1980s and early 1990s, coinciding with two developments: 1) the democratization process and 2) the implementation of the Bamako Initiative.

In many African countries, the late 1980s represented the beginning of democratization and the emergence of a civil society. As a result, many initiatives were undertaken by the population to respond to urgent needs and political issues. These initiatives were encouraged by development cooperation agencies that wanted to support the democratization process. In this context, the associational affiliation of MHOs as non-profit, autonomous, mutual-interest organizations was an easy and flexible way to launch a collective initiative.

During the 1990s, the Bamako Initiative (launched in 1987 by the World Health Organization and UNICEF) was also progressively implemented. Designed to secure universal access to quality primary healthcare, the Bamako Initiative rests on three principles. First, primary healthcare services must attain a sufficient level of self-financing, which requires patients to contribute through user fees. The second is the principle of better access to medicines, particularly generic pharmaceuticals. The third principle is community participation to enhance the quality of care. If representatives from the local community sit on the boards of the healthcare centres, this will make the providers more transparent and responsive. This last principle recognizes that a range of actors should be involved in the healthcare system, including community-based organizations.

However, other regions have also been through a democratization process and have also gone from free healthcare to user fees. What explains the relative uniqueness of the insurance model implemented in West Africa? One explanation stems from the profile and background of the external support organizations involved, and more generally from the colonial history of the region. The development of MHOs is not a purely bottom-up phenomenon since external actors played a strategic role from the beginning. In Senegal and Burkina Faso, for example, the Catholic Church helped initiate some of the earliest *mutuelles* in the late 1980s.

The organizations currently involved in the development of microinsurance in West Africa have some common characteristics. Since the beginning, Belgian and French NGOs (e.g. CIDR and the Belgian NGO World Solidarity) have played an important role in the dissemination of the MHO model, which they considered an appropriate mechanism in an environment lacking in social protection; it was also a model for which they could offer unique know-how. Other external support organizations (e.g. Partnership for Health Reform, United States) followed this trend in West Africa. For similar reasons, French, German and Belgian development cooperation agencies were also active in this field.

Among international organizations, the International Labour Organization through its programme STEP (Strategies and Tools against Social Exclu-

sion and Poverty) engaged in the development of health microinsurance as a strategy for extending social protection to the unprotected population. The main target group of the ILO (workers), and the reference to certain social protection models and normative framework (social economy, not-for-profit sector), also explain the ILO's affinity for the MHO model.⁴

3 What is the target group of the community-based model?

Mutual health organizations are not defined by the profile of the target group and the model is not restricted to poor people (*Box 73*). This kind of organization, belonging to the third sector (the others being the state and the private for-profit sectors) can be adopted for normative reasons and/or because these organizations can provide some services more efficiently.

Box 73

A variety of membership profiles

The members of MHOs associated with the UTM (Mali) range from state employees to groups of informal women workers producing artisan soap. One could say that MHO members come from the entire range of population groups including formal and informal-sector employees, full and part-time workers, rural and urban dwellers, and women and men. In other words, the MHO movement penetrates every possible niche of Mali's society and is growing slowly, but steadily.

Source: Adapted from Fischer et al., 2006a.

The MHOs affiliated with UMSGF (Guinea) generally target people working in the informal economy and those who do not have access to health insurance through their employers. In rural areas, the place of residence defines target populations. Here farmers represent the majority of the village's working population. In urban settings, the majority of the members are artisans and traders. Retired persons, civil servants and other employees can become members as well since MHOs do not discriminate according to socio-economic or health criteria. Employed persons account for 10 to 20 per cent of the urban membership. The illiterate account for 57.6 per cent of membership. The median income is estimated at € 120 (US\$150) per person per year, or € 0.33 (US\$0.41) per day according to the preliminary study carried out in 2000.

Source: Adapted from Gautier et al., 2005.

⁴ Today, the ILO also supports other microinsurance models throughout the world.

A common characteristic of MHO members is that they do not have access to or are insufficiently covered by social security systems, and they could not afford the insurance premiums of for-profit insurance companies, if such services were indeed available (which is rare, especially in rural areas). In practice, most MHO members have variable and irregular incomes from their activities in the informal economy and/or agricultural sector. Nevertheless, MHOs may also cover state or formal sector employees. In West Africa, given the distribution of the population, MHOs are more present in rural settings than in urban areas (*see Box 74*).

Box 74

The target population of the rural MHOs

In rural areas, the target population of most MHOs supported or studied by CIDR in Western or Eastern Africa can be considered poor. However, within the target population, the economic status of households that do register with MHOs is not always known.

To evaluate the profile of the members of MHOs promoted by CIDR in Tanzania, a survey of 185 households was carried out in 2005. The result shows that average and median income of members is higher than non-members' income. The size of member households is smaller than that of non-member households, which suggests that large households have more difficulty paying the premiums.

	Level of income in €		Size of household	
	Average	Median	Average	Median
MHO members	1 061	713	7.4	6.0
Non-members	872	664	8.0	6.0

(€1 = US\$1.26)

Although the amount of the premium does not exceed US\$2.50 per individual and per year, these results clearly show that the less wealthy households are less represented in MHOs. The destitute are not the only ones who cannot join the schemes.

Source: Adapted from Dkhimi, 2005.

4

Do MHOs function (well) and make a significant impact?

The transition from theory to practice provides an opportunity to assess how well these schemes operate and whether they achieve their objectives. To give a fair answer, it is important to be aware of the information available on these issues and the perspective adopted in answering it. So far, most research has

focused on the organizational aspects of community-based schemes. As a result, there is information on the functioning of MHOs and the difficulties experienced in their set-up phases, management and social dynamics.

However, knowing how well they function is different from knowing how they perform according to a defined norm. For example, do MHOs only have to offer social protection to their members or should they actively contribute to the extension of social protection to excluded population? Is the primary objective of an MHO to improve access to healthcare or to improve financial security when households face health shocks? Is the insurance function of an MHO more or less important than the social participation and empowerment potential it makes possible? The answers will differ according to the perspective adopted: is it from the point of view of national organizations, mutual health organizations, external support agencies or national health authorities? In accordance with their autonomous identity, this chapter tries to answer this question in relation to the objectives and perspectives of MHOs.

The same problem arises for the second part of the question concerning their impact: against what criteria can performance be measured and are MHOs effective? In addition, is there enough solid data to address this question fairly? With a few exceptions, the answer is no, which will limit the possible analysis on the performance of mutual health organizations in West Africa.

4.1 Do MHOs function (well)?

In a study of 11 francophone African countries, 622 health microinsurance schemes were identified (Concertation, 2004). This estimation covered not only MHOs, but also a broader range of insurance models. Nevertheless, 88 per cent of the schemes defined themselves as *mutuelles de santé* (MHOs). Of the 622 health insurance schemes, 366 were functional (58.8 per cent). Most of the remainder had just been set up (22.8 per cent) or were in a pilot phase (12.4 per cent). The last 5 per cent were unable to cover their members' claims.

The functioning of MHOs has received a lot of attention from researchers and practitioners. Based on several studies, this section summarizes what has been reported in this area.

Most MHOs have a small membership. With a few exceptions, most cover less than 1,000 persons. Besides the voluntary nature of membership, there are other reasons for this limited penetration: the recent introduction of this mechanism, the limited capacity of the initiating organizations to provide technical assistance and the difficulty in reaching populations beyond

the members of the initiating organizations. In addition, many schemes encounter marketing problems as they strive to raise awareness and educate members. Considering that this function has to be constantly carried out, marketing problems constitute serious obstacles to the stability and growth of MHOs.

Management of MHOs is undertaken by unpaid volunteers, generally elected or designated by the members. A certain discontinuity of daily management occurs due to the voluntary nature of the work, as well as a lack of motivation and management skills. For the same reasons, participation mechanisms and collective decision-making organs do not in practice function as intended. The learning phase of these young organizations, the lack of human resources (leading to some concentration of power), and the continuous administrative work needed to run an insurance scheme could also explain the above observation regarding management. Nevertheless, these organizations show some positive trends towards institutional viability. They constantly try to adapt their management systems to make them more efficient, taking into account their limited resources. For instance, some MHOs decentralize their management system (or put external persons such as healthcare providers in charge) to bring the organizations closer to the members as well as to enlarge their target group.

As shown in Table 44, insurance premiums are often low. The target group frequently cannot afford more, due to its modest and variable income. These low premium levels are also due to the essential objective of MHOs, namely improving access to healthcare by providing insurance that is affordable to a majority of people. Finally, and especially in the early stages, MHOs charge low premiums to attract the target market, since they need to cover many people to make risk-pooling mechanisms effective. It has also been observed that members involved in making decisions about the premium level often prefer to start with small amounts to gain experience with the performance of insurance. When confidence in insurance increases, and an insurance culture begins to take root, willingness to pay might be expected to increase, though this assumption needs to be verified.

Table 44

A comparison of premiums and benefits for selected MHOs

	<i>Mutuelle Wer werlé (Thiès, Senegal)</i>	<i>Mutuelle de Sirarou (Sud Bourgou, Benin)</i>	<i>Mutuelle Leere Laafi Bolem, (Zabré, Burkina Faso)</i>	<i>Mutuelle Têkêyé (Boni, Burkina Faso)</i>
Insurance premium (beneficiary/year)	2,400 FCFA	Single: 2,000 FCFA 2-5 persons: 8,000 FCFA 6-10 persons: 16,000 FCFA 11-15 persons: 24,000 FCFA	2,400 FCFA	500 FCFA
Benefit packages and coverage rate	Primary and secondary healthcare (100%) except echography/scan, medicines and delivery (50%)	Primary and secondary healthcare (100%)	Primary and secondary healthcare (100%)	Primary healthcare (25%)

Source: Fonteneau et al., 2004 (data collected in 2003). €1 = 656 FCFA, US\$1 = 514 FCFA.

If premiums remain low, it is not surprising that benefit packages are also limited. The premiums mainly give access to primary and secondary levels of healthcare in the public facilities (since they are the most important providers in West Africa, especially in rural areas). In some cases, the lack of providers limits the choice of scheme design. In other cases, the premium levels simply do not allow coverage at private healthcare providers.

Even though the premiums are low, there are low premium collection rates as well as high drop-out rates. Combined with the small membership, these factors raise a number of questions relating to member satisfaction (benefit packages, procedures), distribution (premium collection systems) and financial accessibility (levels of income, level of premium, etc.).

To become viable in the face of these challenges, some MHOs join networks, unions or federations. At present, a few effective federations can be found in West Africa, including:

- *Union des Mutuelles de Santé de Dakar* (more than 30 MHOs)
- *Coordination Régionale des Mutuelles de Santé de Thiès* in Senegal (39 MHOs)
- *Union Technique de la Mutualité (UTM)* in Mali (32 MHOs)
- *Alliance Santé* in Benin (27 MHOs).
- *Union des Mutuelles de Santé de Guinée Forestière* (28 MHOs)

In some cases, the creation of a union was part of the initial project (e.g. the UTM in Mali (*Box 75*) and the MHOs in Benin supported by CIDR). This design implies more expensive and technically complicated interventions, but increases the likelihood of sustainability.

Box 75

Union Technique de la Mutualité Malienne

The UTM was created after the Mali Government called on the *Mutualité Française* and French Cooperation to help develop a network of MHOs targeting workers in the informal economy. The Government did so after observing that increasing the availability of basic health services did not result in a significant increase in demand for these services because the population faced difficulties in paying the user fees required under the Bamako Initiative.

The UTM was created in 1996 and became an apex structure providing support to new and existing MHOs. Today, 32 MHOs covering 40,000 beneficiaries are members of the UTM. The Union offers a range of activities as varied as supporting the development of new MHOs, performing feasibility studies, developing new products, monitoring MHOs, representing MHOs at government meetings, and ensuring that the legal and regulatory framework is supportive of MHO activities.

Each MHO designs its own benefit package. In addition, the UTM has launched a highly standardized product, managed at the apex level, which has attracted large segments of the urban population. This product is so competitive that some formal workers covered by the statutory state-sponsored health insurance plan choose to affiliate themselves to an MHO to have access to the plan. This standard plan dramatically simplifies management at the MHO level and allows for the exploitation of economies of scale.

Source: Adapted from Fischer et al., 2006a.

In other cases, like the two networks in Senegal (*Box 76*), the union was created after the member MHOs. In this bottom-up integration, efforts have to be made to create structural relations between MHOs with different organizational cultures and different membership profiles. In addition, management tools and monitoring systems often have to be harmonized to allow supervision and, if necessary, financial flows between MHOs.

Box 76

Coordination Régionale des Mutuelles de Santé de Thiès

The *Coordination Régionale des Mutuelles de Santé de Thiès* was created in the mid-nineties by some MHO leaders in the Thiès Region. The 39 member MHOs benefit from a range of services offered by the Coordination, for example supporting the development of new MHOs, training MHO leaders, conducting feasibility studies, facilitating contracts between health service providers and MHOs and offering health education programmes. In this bottom-up process, the level of integration is lower than in, for instance, the UTM case. The variety of MHO practices (e.g. in terms of design, functioning, benefit packages and risk management) makes integration much more difficult.

Sources: Adapted from Fischer et al, 2006b.

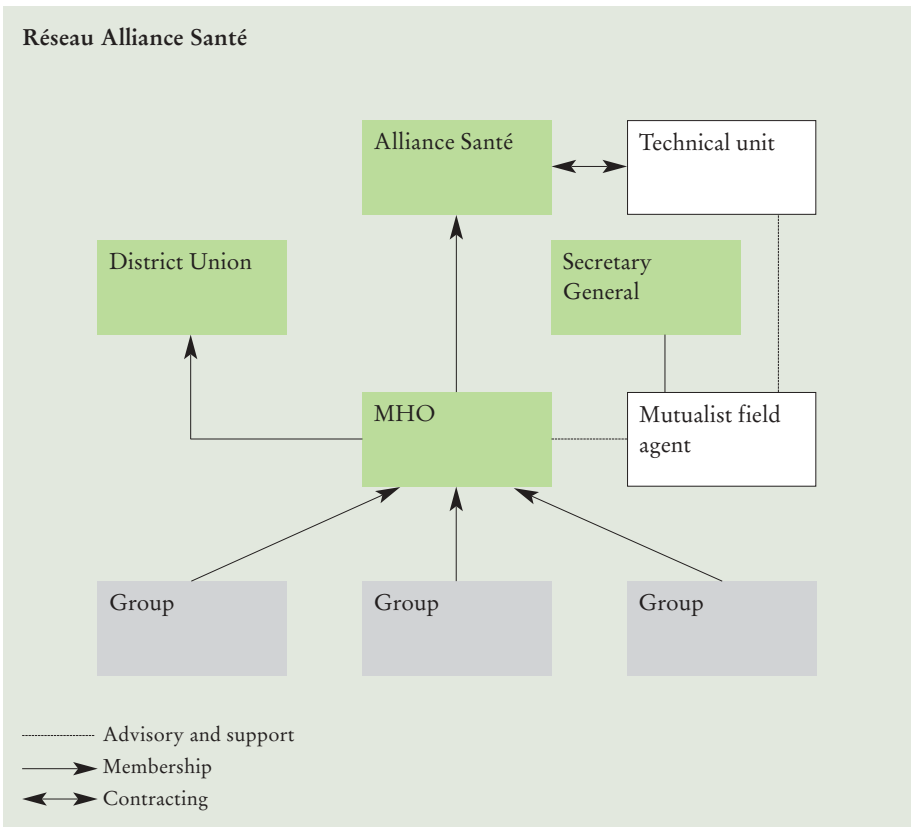
In either case, networks play three roles: a) political role (representation of interests); b) financial support role, for example through guarantee funds or reinsurance mechanisms, and c) a technical role through management support (see Box 77). Federations also represent a way to more “easily” integrate MHOs into a broader social protection system at regional or national level.

Box 77

Réseau Alliance Santé, Benin

Alliance Santé is an association of 25 MHOs representing 21,000 beneficiaries (in 2005). With assistance from CIDR, the association provides technical and financial support to the MHOs. Three mutualist agents employed by Alliance Santé help the MHOs’ board members with technical and financial management, claims processing and organizing their General Assembly. Alliance Santé is the owner of a guarantee fund, which lends money to selected MHOs when their reserves are exhausted, as well as a reinsurance fund to help MHOs to develop their activities. The MHOs pay for these services by allocating 10 per cent of their contributions to the Alliance.

The association also has a technical unit, staffed by a medical doctor and a risk management specialist, which is responsible for the specialized functions of microinsurance management, medical auditing, premium calculation and the design of new services. The technical unit is also in charge of the annual financial reports and external controls. An additional 10 per cent of the premium is allocated by MHOs to finance the technical unit.



The healthcare providers and, more generally, healthcare systems play a strategic role in the *raison d'être* of MHOs. If there is a lack of healthcare facilities, or if they do not offer minimal quality standards, there is no rationale to set up an insurance mechanism to improve access to non-existent or bad-quality healthcare. Even if healthcare providers exist, are financially and geographically accessible, and offer an acceptable level of care, the relationship between providers and MHOs can be problematic. These relationships represent a new factor for healthcare providers used to working as the sole stakeholder for all health-related matters in their districts (Wiegandt et al., 2002). The emergence of new actors in the health field that have other points of view and demand specific conditions can constitute a threat for the providers. In practice, healthcare providers can destabilize MHOs by not fulfilling what has been negotiated, through bad quality of care, unsatisfactory interpersonal relations, disruption in drugs provision and so on (Fonteneau et al., 2004; Criel et al., 2002).

4.2 Are MHOs making a significant impact?

The impact of MHOs could be evaluated through various indicators including a comparison of utilization rates and out-of-pocket expenditure between insured and non-insured persons. It is difficult to answer whether MHOs are achieving an impact, however, due to a lack of data, especially in comparison to control groups. Little information is available on the membership profile, determinants of affiliation and participation, or reasons for drop-out. Moreover, little is also known about the effect of membership: benefits of being insured (more visits when ill, lower out-of-pocket expenditure when visiting, etc.), and the social effects of being a member (better representation, improvement of quality of healthcare). Few systematic studies have been performed to assess the effect of MHOs on accessibility to healthcare services, health service cost recovery and levels of household health expenditure. When research has been conducted, it seems to show a positive impact (*see Box 78*), though a number of questions still need to be answered to understand the impact of these schemes.

Box 78

MHO performance: Some trends

Based on an action-research project in Guinea Conakry, Criel et al. (2002) demonstrated how a local MHO made a considerable impact on the utilization rate (new contact/person/year) of a healthcare centre.

	<i>Utilization by members</i>	<i>Utilization by non-members</i>	<i>Members/Non-members</i>
Primary curative consultations	1.8	0.5	3.6

CIDR also provides some interesting trends. For example, in Tanzania and Guinea, the inpatient ratio has doubled for MHO members. In Benin, the percentage of MHO women who deliver in a health facility is above 80 per cent, as compared to just 50 per cent in the overall total target population. In the MHOs in Comoros Island, Guinea, Tanzania and Benin, health providers agree that members are going to hospitals at an earlier stage.

If the level of satisfaction of MHO members is an indirect indicator of their effectiveness, then MHOs appear to be making an impact. Generally, the level of satisfaction for the services offered by these MHOs is high. Unfortunately, member satisfaction is constantly higher than the retention ratio would appear to indicate: many members who drop out are not dissatisfied with the scheme, but are simply experiencing financial constraints.

<i>Level of satisfaction with MHO services (%)</i>	<i>Very satisfied</i>	<i>Satisfied</i>	<i>Somewhat satisfied</i>	<i>Not satisfied</i>
UMSGF (Guinea)*	50.5	42.4	2.0	5.1
Self-managed Health Organization (Tanzania)**	56.8	20.0	10.6	10.6

* Satisfaction assessment CIDR survey 2004.

** Satisfaction assessment CIDR survey 2005.

5 What are the origins of the problems?

The previous sections give a rather negative impression of the performance and functioning of MHOs. Although interconnected, the problems discussed above do not all share the same origin. Some are more context-specific, others are related to the model itself, and finally some are related to external support.

5.1 Context-related problems

When MHOs began in the early 1990s, many were initiated by national NGOs or community-based organizations. Some problems, such as a lack of monitoring or technical skills, marketing and human resources, can be explained by the young, multi-purpose and inexperienced nature of the initiating organizations.

The limited healthcare supply, together with the low or poor quality of care offered by the public sector, was another context problem. The somewhat “closed” healthcare systems of these countries also meant that new actors like MHOs were not always welcome. Considering the internal problems of healthcare providers (financing mechanisms, lack of human resources and motivation of employees, etc.), the presence of MHOs – and even more, the presence of their external support organizations – led to expectations from the healthcare providers. If these expectations (training, financial incentives) were not delivered, healthcare providers might not act as “partners” of MHOs, but rather create obstacles to their functioning despite their official positive stance.

This micro-reality (goodwill of healthcare providers) must be combined with a more macro factor, namely the national political will to recognize and promote community-based insurance schemes. In recent years, several countries, including Benin, Senegal, Burkina Faso and Guinea, have included microinsurance schemes, and sometimes specifically *mutuelles de santé*, in their national health policies. In the same way, many West African Poverty Reduction Strategic Papers (PRSPs) also mention microinsurance as a poten-

tial tool for social protection or as a source of financing for the healthcare sector. However, these policies are not always translated into operational measures.

In West Africa, only Mali and Senegal⁵ have voted for a regulatory framework for MHOs (Senegal) in particular or *mutuelles* (Mali) in general. In some other countries, legislative preparatory work is under way.⁶ At the regional level, a project (*Appui à la construction d'un cadre régional de développement des mutuelles de santé dans les pays de l'UEMOA*) was launched by the West African Economic and Monetary Union, French Cooperation and ILO/STEP in 2004. Still, most MHOs operate under the national laws regulating associations or under the legal statute of their initiating organizations. Although this situation is not a major problem in the day-to-day management of the schemes (Fonteneau et al., 2004), MHOs and their support organizations are petitioning for an appropriate regulatory framework to take into account the specific characteristics of MHOs and to promote the creation of such organizations rather than to discourage it.

5.2 Model-related problems

Some of the problems identified are related to the specific community-based insurance model. However, one nuance has to be recognized. The model-related problems presented below cannot be disconnected from the West African context where this model has mainly been implemented. This means that the model, as such, may not automatically lead to the same consequences in other environments.

Until now, most MHOs have been run by unpaid volunteers on a self-management basis. Even if the model's essential characteristics entail the active involvement of members in the political and strategic decision-making, this does not mean that the managers have to be unpaid, and possibly unmotivated, members. Financial prudence (especially at the beginning) and scarce resources explain why this has happened. With a few exceptions, the instability and dissatisfaction of volunteers are now recognized as recurrent problems. Solutions can be found (e.g. external funding, effective use of premiums), but are not always sufficient.

All participation-based or collective-action stories demonstrate that these processes take longer than top-down approaches (Esman and Uphoff, 1984). If the specific "learning" characteristics of these organizations are acknow-

⁵ In Senegal, the *Loi sur les mutuelles de santé*, voted in 2003, is not yet in force because application decrees have to date still not been promulgated.

⁶ In some countries, this process is complex because various ministries (e.g. Public Health, Social Protection, Labour, Social Affairs) claim administrative responsibility for MHOs.

ledged – especially in the democratization processes – this also means that more time is needed to make decisions when everything depends on the goodwill and choice of the members. It also explains why it is sometimes difficult for MHOs to be effective in the short run.

Social factors play a role in limiting the model's effectiveness. For instance, membership in an MHO is often determined by attributes like religion or gender (Jütting, 2002). This will always present a problem for MHOs, especially in their efforts to enlarge membership. In the same way, measures have to be taken to protect the scheme from pitfalls such as adverse selection, moral hazard, over-prescription or fraud. However, many of these measures tend to be unpopular. Develtere et al. (2004) reported member dissatisfaction with initial waiting periods, mandatory affiliation of all family members, identity and insurance status verifications and exclusion of certain treatments. In self-managed insurance schemes like MHOs where the proximity between members is a trust factor, it is not difficult to imagine the difficulties in the application of these technical measures.

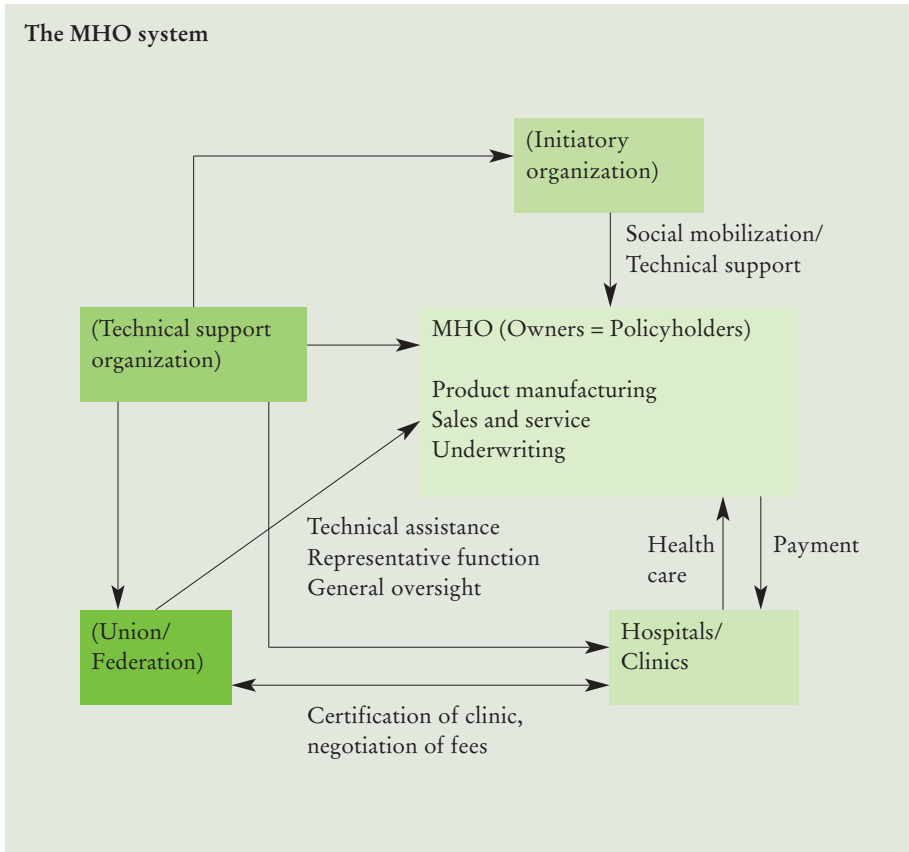
MHO membership is normally voluntary. However, faced with the problem of low enrolment, some organizations have attempted to make membership compulsory for the entire target group, or automatic (e.g. once you are member of an organization, you become a member of the MHO). In most cases, these attempts failed and were discontinued because of members' refusal or because of a lack of capacity to ensure implementation.

The emphasis on financial accessibility or affordability results in low premiums and limits the benefit packages. Increasing the premium level could implicitly exclude current and potential members. This limitation is not intrinsic to the MHO-model, but linked to the MHOs' primary target group, namely low-income people.

Last but not least, MHOs often have complex structures due to the diversity of actors involved, as illustrated in Figure 25. Initiating organizations play a role in the social mobilization process and can provide some technical support to MHOs. Technical support organizations (national or international, on a permanent or sporadic basis) are also involved and can have a significant influence when the scheme is new. Where they exist, federations strive to assume the responsibilities of the technical support organizations over time. Finally, the healthcare providers play an instrumental, although not always constructive, role. The variety and diversity of actors – each with a necessary short-term function – complicates an already complicated decision-making process.

Figure 25

The MHO system



5.3 External support-related problems and limits

The development of community-based health insurance cannot be analysed without considering the pivotal role of technical and financial support organizations. External support organizations are diverse.⁷ Nevertheless, with a few exceptions, some common features of the external support role can help explain the MHOs' current situation.

Microinsurance was a new field for all external support organizations involved in establishing them. Some were specialists in health insurance in their own countries (France, Belgium), but did not have specific experience in Africa. Others had experience in Africa, but in other domains such as microfinance. For all of them, support of health insurance for populations excluded from social protection schemes represented a new area of social engineering.

⁷ The term "external support organization" refers to technical and/or financial support organizations. This section only deals with one aspect of their interventions, namely direct support to MHOs. For instance, the political input provided by ILO/STEP and others to influence social protection reforms is not addressed in this chapter.

Some choices were made. With a few exceptions, there was an implicit consensus that the benefit package and premium amount should be balanced from the beginning. Schemes do not offer more benefits than what members are willing or able to pay for. To a certain extent, financial sustainability and community-based learning processes were preferred by external support organizations to artificial short-term successes.

The social participation process needs time. However, the process is often difficult to support because of the limited timeframe of an external intervention and the contingencies of funding agencies. In practice, this has meant that support organizations have often had to stop or restrict their support at a time when MHOs still needed to strengthen their activities or their governing bodies, or overcome difficulties.

In general, support organizations did not attach equal importance to social and technical aspects. The community-based approach implies social mobilization, education, social cohesion and ownership. This led to an important emphasis on the social aspects of health insurance to ensure social viability and the permanence of the dynamics created, while insurance product design was sometimes neglected. This can be explained by considering the circumstances (i.e. limited choice between healthcare facilities, insufficient knowledge of healthy behaviour, low income, etc.). In addition, it took time to develop relevant methodologies, appropriate management tools and monitoring systems.

From the beginning, external support organizations made some rational choices, motivated by institutional sustainability preoccupations and/or cost-reduction constraints. Apart from not subsidizing claims, intensive financial support was often limited to the start-up phases. However, logically, leaders of fledgling MHOs faced many problems they could not solve due to their lack of know-how and experience.

Most support organizations use participatory approaches, which require an active involvement of the target group during the set-up phase, including data collection for the feasibility study. However, it is not easy to find a balance between the technical expertise needed for a feasibility study and the necessary ownership by the MHO's members. Self-management and voluntary work are also part of this participatory approach, which creates a set of related problems as discussed above. There are solutions, for example paid professional or remunerated officials, but they raise the stakes for MHOs in terms of cost, autonomy and sustainability, and for the support organizations' exit strategies.

Many MHOs were created in isolation; networking with other MHOs and/or social protection systems at regional or national level was often not planned at the outset. Some external organizations did not originally favour this networking. Although some intrinsic features (especially the community-based one) could explain this oversight, it is now recognized that efforts have to be made to forge structural relations between the actors early on in the process. This is not easy, nor is it without risks. Ideally, each MHO should build its own identity before becoming involved in upper-level dynamics.

These observations demonstrate why it has been, and still is, difficult to find the appropriate balance between the nature of community-based organizations and the design of the support intervention.

6 What is the added value of this model?

The community-based model is not the easiest way to organize health insurance. The West African context, with its nascent democratization process, high levels of poverty, mismanaged healthcare facilities and limited availability of skilled human resources, certainly does not facilitate the implementation of this model. So what is its added value?

MHOs are more than just institutions selling insurance to clients. In this respect, MHOs have to be assessed not only on the effectiveness of their insurance provision function and their potential role in the extension of social protection, but also taking into account the effect of their social participation processes.

Access to healthcare in Africa (and elsewhere) is not only a matter of insurance. Most existing statutory social protection systems in Africa are not effective (*see Chapter 1.3*). Reform processes are underway in many countries, but it is obvious that successful social protection reforms need to include input and representation from the population. It is also recognized that reformed social protection systems will include a range of public as well as private tools (ILO, 2002c).

Intrinsically, MHOs have some added value. Through their non-profit nature, their non-exclusion policy and their low premium, they guarantee access to some services, even if the coverage is limited. Participation not only contributes to the client's satisfaction, but also to empowerment and learning. In this respect, MHOs create advantages through their embedded control and participation mechanisms. Although research on participation mechanisms is still required, MHOs are part of the democratization process. Moreover, one advantage of this model is its influence over the management of health services (management transparency, security of financial resources,

etc.) and its ability to improve healthcare quality (*see Box 79*). The size of the MHO strongly reinforces this power. While the power should not be overestimated, some pressure can be put on health systems, especially when MHOs are organized into a federation. For example, many MHOs are taking action to get rid of public agents who do not carry out their duties.

Box 79

The power of collective action

In 2004, when asked to renew their premiums, no members of Réseau Alliance in Borgou-Benin wanted to do so. The reason was that the midwife of the dispensary contracted by the MHO had decided that she would not attend to pregnant MHO members during the weekend. The official of the network “Alliance Santé” organized a village meeting with both members and non-members. The midwife had to apologize to the participants and commit herself to avoiding any discrimination in the future. Following this meeting, the number of insureds increased from 1,000 to 1,200.

This power also exists in the negotiation of prices for services delivered to members. Some MHOs have obtained lower fees for their members. Although this is not always the case, this fee reduction can be seen by health-care facilities as an added value in being more financially accessible to the population. Empowerment of the members who learn to influence the quality of healthcare is also an added value for MHOs compared to non-self-managed modes of insurance.

7

Conclusion

Mutual health organizations, a community-based model for insurance provision, have been active in West Africa for over a decade. For many people, it is the only “formal” social protection they have. The model is fraught with problems, but a clear understanding of their origins helps to identify solutions that can enable this approach to fulfil its potential in being more than just an insurance mechanism.

Nowadays, other models (e.g. health microinsurance products offered by microfinance institutions like AssEF in Benin) are also seen in West Africa. Many try to adopt the community-based philosophy of MHOs and inherit the advantages of the model, while increasing effectiveness by improving the functioning and increasing the scaling-up potential. Although it is too soon to judge whether these new approaches will succeed, this evolution toward a more diverse landscape of health microinsurance models is positive and could provide wider coverage through collaboration with NGOs, microfinance institutions, cooperatives and the like.

Despite this positive diversification, some questions remain. For example, how can community-based health insurance systems be better supported to fulfil their multi-purpose functions? Moreover, are these health microinsurance systems relevant without a broader redistributive social protection mechanism?

Institutional options for delivering health microinsurance

Ralf Radermacher and Iddo Dror¹

The authors appreciate the detailed and useful comments provided by Klaus Fischer (Laval University), Bénédicte Fonteneau (University of Leuven) and Michael McCord (MicroInsurance Centre), as well as the stimulating discussions with David Dror (Erasmus University Rotterdam) and Gerald Leppert (University of Cologne).

Health insurance entails the transfer of health risks in return for a premium payable in advance. This succinct description suggests that the arrangement entails flows of funds and information in two directions: from the client to the insurer and from the insurer to the client. The party with the most control of these flows of funds and information can influence the business process to its advantage.

This notion that one party would seek an advantage over another implies that conflicts of interest can occur between insurers and insured. But is this the case in health microinsurance provision? And if so, does the institutional option (model) for delivering health microinsurance have an influence on such conflicts of interests and efficiency in the provision of insurance? This chapter looks at these questions by offering a basic typology of the different business process options identified in health microinsurance provision. Such a typology will help identify conflicts of interest and remedy inefficiencies in the smooth bi-directional flow of funds and information.

This chapter first summarizes the main types of health microinsurance providers and then analyses their relative effectiveness in meeting the needs of the low-income market over the long term.

I Institutional options

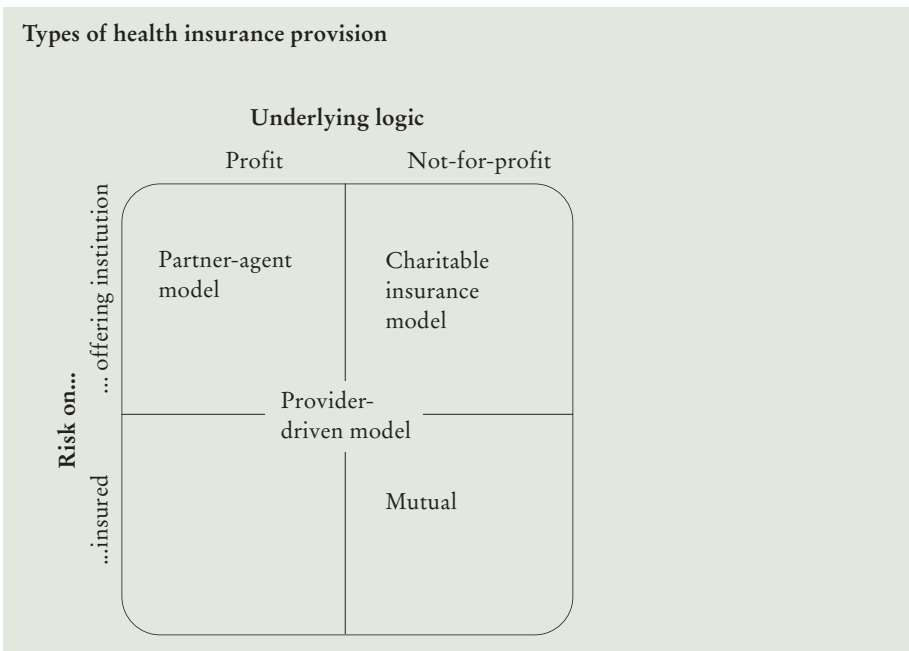
All insurers must satisfy the basic value proposition, namely that they reduce the long-term cost of the risk for the insured. An additional requirement, which is specific to microinsurance, is that the type of organization should function effectively within an environment of low premiums. As discussed in Chapter 2.1, such a situation might lead to severe rationing of benefits and, when coupled with a broad variety of insurance needs for the heterogeneous

¹ References in this chapter to the following Indian microinsurance schemes are drawn from the authors' experiences: BAIF, Arogya Raksha Yojana and Voluntary Health Services.

low-income market, result in product fragmentation to suit many small groups of clients. To reduce the long-term cost of risk, the insurer has to aggregate many individual risk profiles that have different statistical distributions and that can be diversified over time. While some types of microinsurance providers can fulfil the requirement for large numbers more easily than others, they might suffer from other weaknesses in the business process.

The typology presented in this chapter considers four main providers of health microinsurance: 1) licensed insurers operating the “partner-agent” model, 2) the charitable insurance model, 3) healthcare providers that also operate health insurance and 4) the mutual model discussed in the previous chapter.² This typology results from distinguishing organizations along two dimensions: a) the primary motivation for entering the market, since this motivation influences the design of the business process and hence the product, and b) the entity bearing most of the risk of losses, as depicted in Figure 26. The description of the organizational models that follows contains a discussion of their advantages and disadvantages in fulfilling business-process functions, and their effectiveness in minimizing (or not) conflicts of interests within the system. The analysis also takes into account certain differences, such as governance mechanisms.

Figure 26



² The authors recognize that there are certainly other institutional arrangements as well, but the typology described here emerges most clearly from the case studies. Furthermore, one could divide these four provider types into sub-categories, some of which would have “hybrid” characteristics of more than one provider.

1.1 The partner-agent model

As described in Chapter 4.2, under the partner-agent model the relationship between the policyholder and an insurance company (“the partner”) is facilitated by an intermediary (“the agent”) such as an NGO, a microfinance institution or any other organization with close contacts to the target group. Owing to the regulatory conditions discussed in Chapter 5.2, examples of the partner-agent health microinsurance model are common in India, including:

- VimoSEWA and ICICI Lombard
- Shepherd and United India Insurance Company (UIIC)
- Karuna Trust and National Insurance Company (NIC)

The insurance company is responsible for all decisions affecting product manufacturing, sales, servicing and maintenance of long-term sustainability, i.e. it carries the risk. Although it may consult the agent organization when designing a product, the insurer maintains control over the strategic operations that define the risk transfer mechanism.

The agent deals with sales and product-servicing within the boundaries of the products that the insurance company is allowed to sell, and at commissions that meet the regulatory limits or are agreed on with the partner. Agents have better knowledge of (and ties to) the target market, but their primary role is to represent the insurer to the clients. This is an area where conflicts of interest might arise, as the agent organizations usually regard themselves as advocates for their clients, and might feel uncomfortable communicating the insurance company’s position.

Consider the case of a claim settlement procedure, where the agent needs to defend the insurer’s position to its clients. If a conflict arises over whether a claim is valid and should be paid, the agent might need to agree with one side, running the risk of alienating the other. Usually, its position as an agent of the insurer means having to side with the latter, and communicate the rejection of a claim to the client. If such cases occur frequently, agents might find their reputation in the community damaged and the community’s trust in them – the very attribute that attracted the insurer to the agent – will diminish or be lost. Therefore, in practice, agents such as VimoSEWA occasionally cover claims from their own coffers if they feel that the claim rejection is unjustified.

Another potential conflict arises with adjustments to the premium levels. For example, after BAIF's claims ratio had exceeded 100 per cent, UIIC decided to increase the premium charged to BAIF's insured clients by about 80 per cent. Unable to justify such a rise to its clients, BAIF decided to turn its insurance scheme into a mutual.³

As illustrated in Figure 27a, neither clients nor healthcare providers have direct input into the production process, and bear no responsibility for long-term sustainability. The agent's role is usually also confined to sales and after-sales service, although the latter is sometimes dealt with by the insurer directly or through a third-party administrator (TPA). For example, the Arogya Raksha Yojana scheme near Bangalore, India is linked up with ICICI Lombard for health insurance, and has contracted a TPA for administration (*Figure 27b*).

In the partner-agent arrangement, each side can benefit from the comparative advantages of the other, but a couple of inherent problems often remain unresolved. An insurance company is usually interested in selling a pre-designed product (often a scaled-down version of its products for the formal sector). This type of product is easier for the company to monitor and does not need to be priced anew. Some insurance regulators also require new products to be registered and few companies are willing to do this for every agent/community; usually, only large agent organizations have the negotiating power to push for a tailor-made product.

This lack of flexibility in product design is particularly important because, as discussed in Chapter 2.1, product features are more likely to influence adoption among the target population in health insurance than in life or property insurance. However, this problem can be solved in the partner-agent model. Due to its proximity to the target group, the agent should be well placed to explore the actual demand, while the insurer can use its actuaries to turn the demand into a well-priced product. This was the arrangement for Karuna Trust, which engaged in a detailed demand analysis before linking up with NIC. Although the benefits demanded and the price negotiated caused a severe headache for NIC's actuaries, the insurer was willing to pilot this scheme. Similarly, Shepherd and UIIC designed a benefit package together making use of their respective competencies.

³ BAIF is an NGO working on rural development in India. Coming from cattle breeding, it subsequently expanded its activities to a broad variety of services and now provides microfinance and, in one pilot area, life and health microinsurance.

Figure 27a

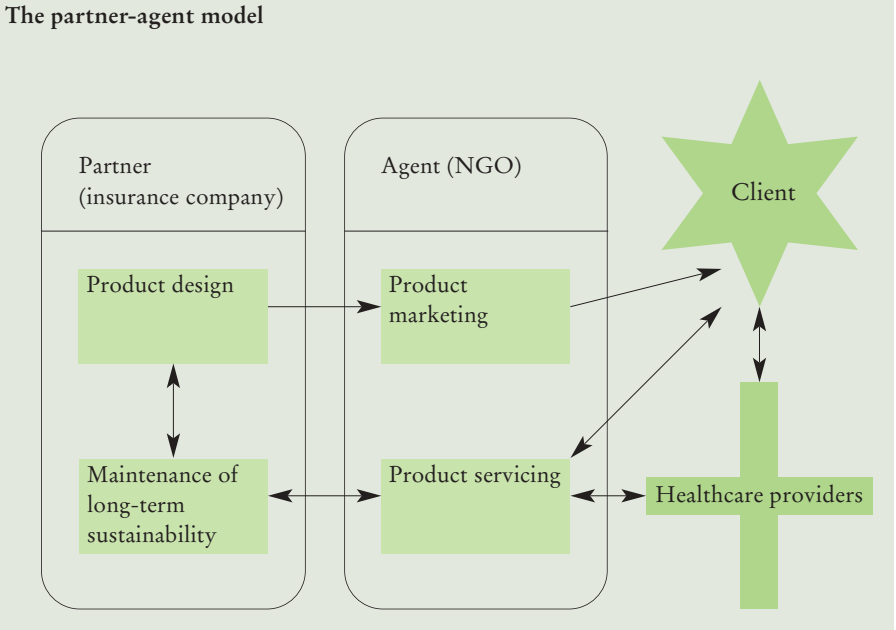
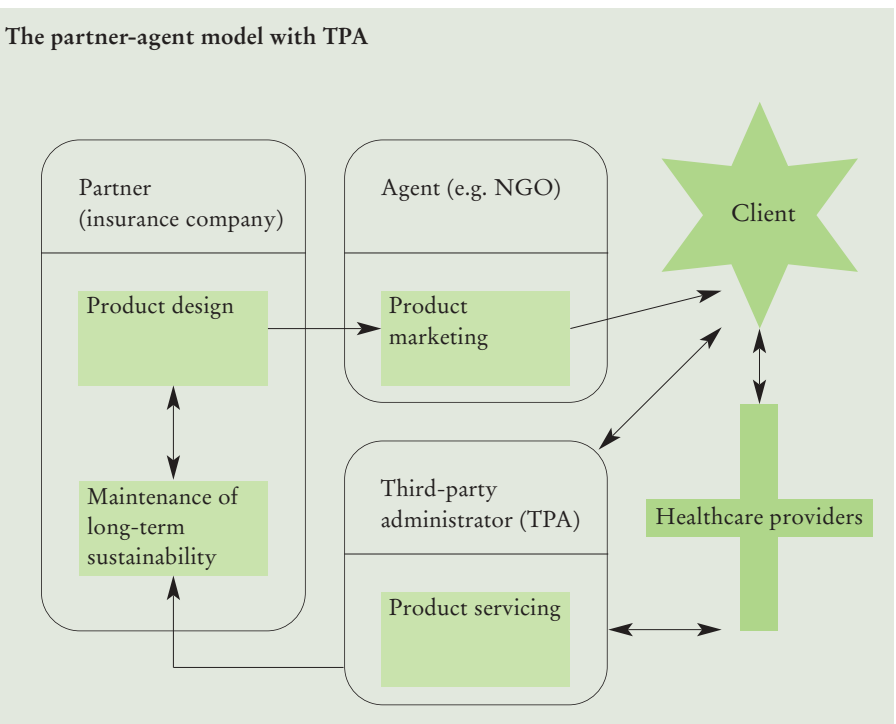


Figure 27b



For health microinsurance, the agents' real comparative advantage (and hence their source of attractiveness for the insurer) is highlighted in the sales process. Insurers, which often lack a relationship of trust and access, both physical and psychological, to potential clients, rely on the agent's proximity to the market and the trust built up over the years through the agent's other operations. However, market penetration is one thing, but complete transparency another: clients quickly realize that there is little incentive for them to provide information about their health status or about a neighbour who they know is withholding information, and so the flow of information in both directions is incomplete in the partner-agent model. This constitutes an increased risk to insurance companies for which their shareholders (logically) expect to be compensated by increased returns (invariably, *ceteris paribus*, leading to higher premiums). Higher premiums in turn result in clients' increased demand for "value for money" and thus amplify moral hazard (again a higher risk for the insurer). Thus, a vicious cycle of dysfunction can evolve which may cause the opportunities inherent in this model to be squandered. For as long as risk and returns are not balanced from the insurer's perspective, there will be no incentive to enter the market in a meaningful manner.

This incentive problem is amplified when it comes to product-servicing and claim verification. The insurance company may expect the agent to verify the claims, and if so hopes that the strong ties of the agent with the target groups will ensure a good flow of information. However, as in any commercial insurance scheme, clients have no incentive to provide information that will benefit the insurance company at their (or their neighbour's) expense. Clients might even consider it legitimate to cheat a large company in a distant city following the logic: "we are poor and they are rich, so they can pay." This manifestation of the "*them and us*" paradigm implies an attachment to certain networks, norms and trust at the community/client level – which captures the essence of the social capital concept – at least from the perspective of Putnam (1995) and his followers.⁴

As insurance companies experience this problem with clients from every market segment, they establish monitoring mechanisms for verifying claims. However, these mechanisms are costly, and in the context of microinsurance may be prohibitively expensive to the point where affordability for the poor

⁴ The concept of social capital has been the subject of much interdisciplinary examination over the decade following Robert Putnam's 1995 article "Bowling alone: America's declining social capital". It is generally accepted that if authors wish to use the term, they should define how they will use it. While it is not within the scope of this book to develop a definition of social capital in the context of health insurance for the poor, references to some useful reviews of the subject by Farr (2004), Manski (2000), Portes (1998), Sobel (2002) and Woolcock (1998) are included in the bibliography.

could be jeopardized. Furthermore, attempting to solve this problem according to the logic of the traditional business process for high-net-worth clients is the hallmark of scaled-down commercial insurance products – hardly an innovative health microinsurance solution.

To solve this problem, VimoSEWA trained its people in claims investigation techniques, established a claims committee with appropriate expertise and persuaded its insurance partner to allow it to adjudicate claims. However, more can be done: synchronizing the clients' incentives with the incentives of the insurance company (e.g. through profit-sharing arrangements) modifies the business process in such a way that the problem might not arise in the first place, as clients would then have an increased incentive to keep information flowing (perhaps not about themselves but about others who are cheating the system).

A similar (though not identical) application has been extensively documented in the related field of microfinance, whereby mechanisms (notably joint liability and contingent renewal) have been put in place to use the power of communities to compensate for the information advantage customers had over the lender (Van Bastelaer, 2000). This is an excellent example of social capital at work – replacing traditional, more formal (and costly) means of evaluating creditworthiness used by commercial banks with peer pressure and character-based lending (DeFilippis, 2001).

The main point is that a true sense of ownership and “buy-in” among the clients (preferably through leveraging communities' social capital) is indispensable for a successful health microinsurance scheme, and might be even more important than in other business areas of corporate insurance companies.

1.2

The charitable insurance model

Charitable insurance models cover a wide range of institutional options, which all share two important features: (i) being non-profit and (ii) not putting the risk on the insured. It is especially the first feature that distinguishes this model from the partner-agent model (this is at least true for the insurer's side), and from some healthcare provider-driven models where the prime objective is to increase utilization of their facilities. The degree of risk on the insured and their involvement in the business process distinguish it from the mutual model (to be discussed later in this chapter). Providers of this kind of insurance can be NGOs, religious associations or any other well-meaning organization. Thus, this model can be applied to some government-supported initiatives as well.

The motivation for establishing the insurance scheme is to increase clients' access to care. The motivation is purely social, resulting primarily from the development background of these organizations. The paternalistic and social characteristics of the charitable model do raise some potential conflicts of interest, notably that of placing priorities of the clients behind those of other stakeholders (such as donors or NGO management). Furthermore, in situations where sustainability is based on permanent external financing, the scheme may neglect the education of its clients on proper insurance mechanisms, which might make it difficult to create an insurance culture among the target market.

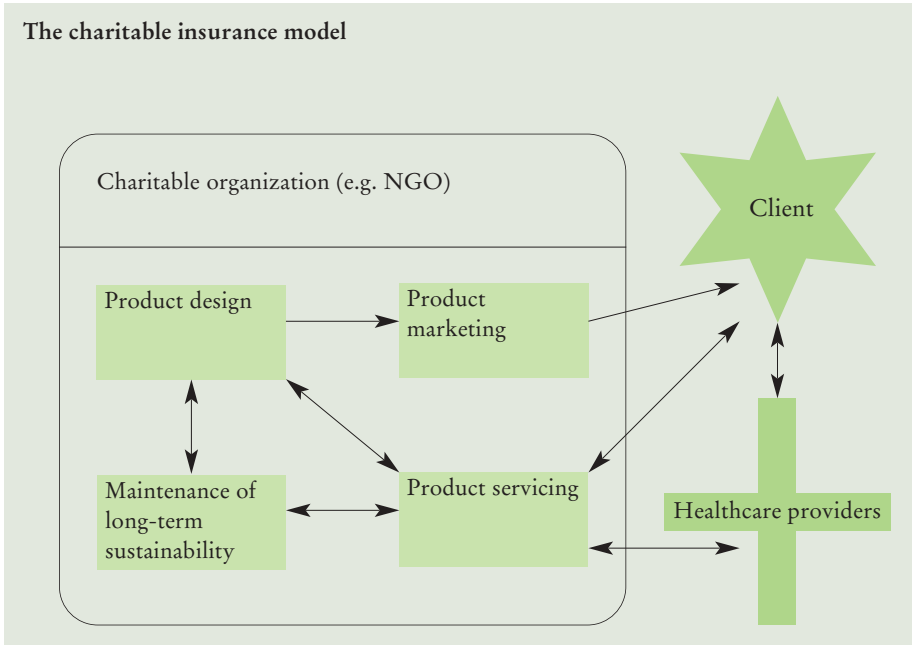
As most of these organizations have worked with the target group for quite some time, they are familiar with the requirements of prospective clients. However, turning this into an actuarially-priced product is difficult since these organizations usually lack insurance expertise. The health insurer bears the risk of losses. Profits generated in some years are kept as reserves for future losses. All activities of the business process are performed by the offering institution, sometimes with involvement of the target group. The responsibilities of the charitable insurer are illustrated in Figure 28.

VimoSEWA operated its health insurance under this model from 1996 to 2002. In 1996, VimoSEWA found the health insurance products available on the market unsuitable for its clientele. The administrative procedures did not at all respond to the needs of poor women who had to wait a long time before being reimbursed. Thus, VimoSEWA terminated its partner-agent relationship and became its own charitable insurer, but after the 2001 earthquake in Gujarat, the limits of being a small-scale stand-alone insurer became obvious and VimoSEWA entered a new partner-agent relationship.

Yeshasvini Trust, in India, is a mixture of the charitable insurance model and the provider-driven model (discussed below). Initiated by healthcare providers, it is now operated by a trust in which the cooperative sector of Karnataka is equally represented. The healthcare providers shaped the benefits, which are still provided today; the cooperative sector shaped the sales and business process. While the influence of the providers on the product manufacturing process makes it a provider-driven model, the fact that the trust as a whole, which bears the risk (supported by the Government of Karnataka), is not-for-profit and conducts all parts of the business process, makes it a charitable insurance model.

Figure 28

The charitable insurance model



For many charitable insurance schemes, achieving sustainability is a major challenge due to their social background. For instance, they may find it more difficult to reject claims, even if the claim is not fully justified. This is due to what is sometimes referred to as the “dirty work hypothesis”: managers of charitable institutions might feel that they threaten the institution’s reputation by rejecting claims since, unlike in the partner-agent model, the charitable institution cannot blame anyone else to justify an unpopular decision.

Some charitable organizations take this social motivation logic even further, to the point of not even considering sustainability of the insurance scheme an objective. Instead, it is simply assumed that losses will occur, and will need to be covered with external subsidies.

This social interpretation of this kind of organization’s mission also affects the design of its business processes in insurance: the flow of information in the sales process is mainly unidirectional towards the client. Information on how to claim benefits is provided, but no information about pre-existing diseases is sought. The distribution process is usually conducted through the organization’s own staff who also have other duties. Voluntary Health Services (VHS) in Chennai (India), for example, distributes its insurance product through mobile health workers or in its health centres. Its objective is to cover those who need it most, not necessarily balancing the bad risks with good risks to stabilize the risk pool.

Charitable organizations usually agree to relatively unrestricted provision of benefits and product-servicing is also kept simple. For instance, VHS and the Society for Social Services (Bangladesh) both operate their own health facilities and clients are obliged to use them. However, unlike provider-driven models (described below) the motivation here is not to increase the utilization of their own (commercial) facilities, and consequently their financial viability, but rather to ensure that their insured population has access to health services.

Maintenance of long-term stability is arguably the weakest point of the charitable model. Often management does not regard financial stability as desirable: “We do cherry-picking: we only pick the bad cherries,” a manager of VHS points out – nicely illustrating the different underlying mindset. The Society for Social Services can in no way cover the administrative costs of its health programme through insurance. They amount to over 2,000 per cent of the premiums collected! Thus, their means of ensuring sustainability is through a donor rather than a market-based solution (such as reinsurance).

1.3 The provider-driven model

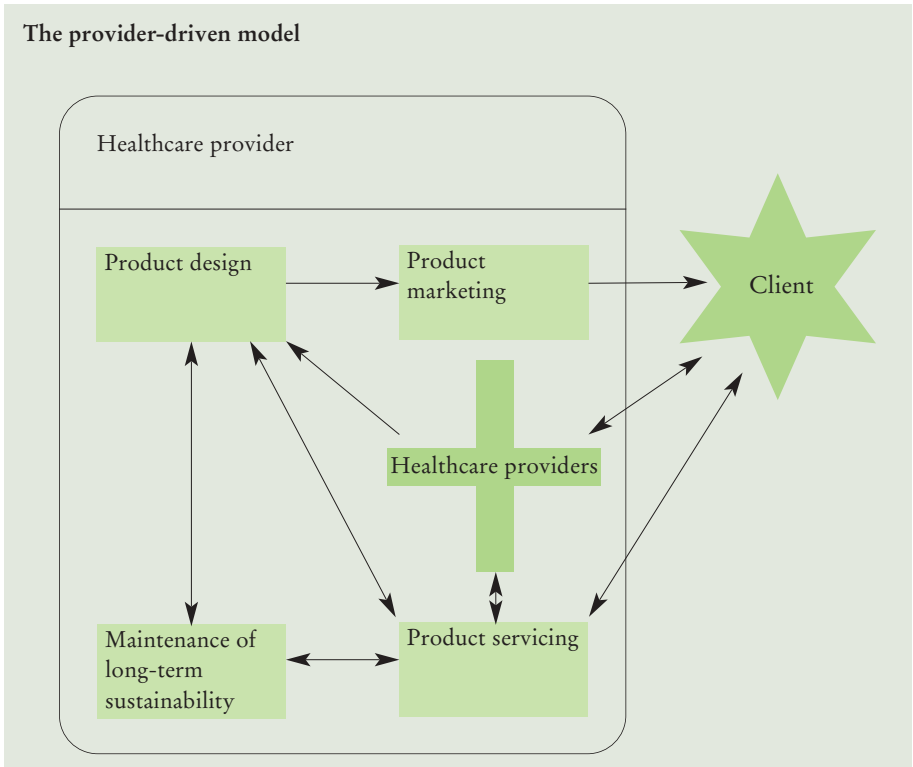
Providers of care (e.g. hospitals, clinics) may launch an insurance scheme to generate larger volumes of business in dedicated facilities, as well as to open up access to healthcare at different unit prices for different segments of the target population (*see Figure 29*). The unique feature of this model is the involvement of the healthcare provider in the design of the business process (including the financing side).

This is an important feature: a healthcare provider directly deciding on the benefit package is significantly different from an insurance company setting up its own healthcare facility, or directly employing providers to service a product. The difference might seem rather theoretical, but the question of ultimate control over the design of the benefit package is not trivial. Consider the case of open-heart surgery – if the decision-maker is a surgeon, whose services are not in great demand due to the high cost of operations, the likelihood of this benefit being included in the package is higher than if the decision is taken by insurance professionals or clients.

This explains why many provider-driven schemes restrict clients' choice to the provider's facility or its health professionals, or like Grameen Kalyan and BRAC MHIB in Bangladesh, significantly limit the benefits available outside their own healthcare providers. The clients pay their premium to the healthcare provider, which in turn offers clients a financing mechanism that enables them to consume health services, presumably in a more cost-effective manner than paying for them out of pocket. At the same time, the provider benefits from this arrangement in several ways: a) it increases its potential

Figure 29

The provider-driven model



market by enabling more people to use services, b) the provider restricts the choice of customers to its facility and c) the provider receives revenue from those who would otherwise have not sought treatment, or would have done so elsewhere, or to whom it would have provided services anyway – but for a lower price or for free.

In some schemes, the premium is used directly for operating the health facility, while the provider commits to providing certain benefits to the clients if needed, with provider payment on a capitation basis. Hence, the risk in bad years rests with the healthcare provider which then needs to provide the services. In good years, the surplus is absorbed by the healthcare provider. In these payment systems, the provider has an incentive to underprovide or compromise on the quality of care.

In other schemes, the premium collected is released to the healthcare provider according to the services rendered or cases treated (fee-for-service, case-based payments). This mechanism requires a stricter separation between insurance and healthcare provision. For instance, Yeshasvini Trust fixed the prices for more than 1,600 operations and reimburses the network hospitals according to the surgery carried out (i.e. case-based). Fee-for-service is applied in the Nkoranza Community Health Insurance Plan, Ghana (*see Box 80*).

Box 80

Nkoranza Community Health Insurance Plan

St. Theresa's Hospital is the major provider of inpatient services in the district of Nkoranza in rural Ghana. In 1992, it launched the Nkoranza Community Health Insurance Plan, a provider-based health microinsurance programme, in response to the inability of residents to pay out of pocket for health services, especially hospitalization. The insurance covers inpatient services at the hospital in full including the cost of prescriptions for drugs not available in the hospital, referral to other hospitals and some outpatient services.

When clients seek care, they hand over their insurance card to the treating doctor or nurse who writes the insurance number on the patient's admission card. Based on the services rendered (fee-for-service) a monthly bill is sent to the insurer. The prices for the services are fixed by an external body, the Diocesan Health Committee, on an annual basis and are valid for all Catholic Hospitals in the region. The insurance reimburses the hospital for all services rendered, but is not entitled to check their appropriateness. Although not observed in this scheme, the fee-for-service mechanism with institutional splitting (between insurer and provider) provides an incentive for the provider to over-prescribe services to increase financial returns.

Source: Adapted from Atim and Sock, 2000.

Most healthcare providers do not have the administrative (or sometimes the financial) capacity to run a viable health insurance scheme. Pricing products actuarially is certainly a weak point even though the data available about healthcare expenses might be relatively good in this model. The main problem of the model is in product servicing: in the case of fee-for-service payments, the healthcare provider might have an incentive to provide more services than necessary, while the insurance provider needs to maintain its long-term stability. The unification of roles of provider and purchaser of services may thus create conflicts of interest.

1.4 The community-based/mutual model

Mutual benefit societies, also referred to as community-based health insurance schemes or mutual health organizations, are voluntary non-profit systems of risk-spreading based on the ethics of mutual assistance and solidarity (see Chapter 4.3). This model is based on the premise that the risk is borne by the insured, who are the owners of the scheme, and that profits are in some way retained for the benefit of the insured.

However, community-based and mutual schemes are not identical. The community-based model is usually made up of a small, local group formed on the basis of the social ties developed in day-to-day interaction. The management has little professional expertise in insurance and the degree of involvement of the members is usually quite high. Mutual schemes, on the other hand, have a long history as providers of social security.⁵ They are often built on religious or common political lines and provide insurance services to their members. Mutuals are often much larger than community-based schemes and usually have professional management. Due to the group size, and the consequent absence of personal links between the members, there may be less social cohesion in mutuals than in community-based schemes.

In the community-based/mutual model, clients or members play the central role. As illustrated in Figure 30, they are responsible for all aspects of product manufacturing, sales and servicing, as well as for the maintenance of long-term stability. Members are both the insured and the insurers, as the group underwrites the risk collectively. As owners of these societies, members are actively involved in management and decision-making. They have a direct influence on determining the scope of coverage and the size of contributions. This first-hand knowledge of needs and preferences gives mutual schemes a special advantage in designing the products. The involvement of the members ensures a high degree of satisfaction with the product; but this is conditional on true and representative inclusion in the design process, as well as on fair and transparent management of the scheme. At the Union des Mutuelles de Santé de Guinée Forestière (UMSGF), the general assembly of the members decides on the benefits covered. However, to design and operate an insurance system, specialist knowledge is necessary and this is the Achilles' heel of many mutual schemes. Sometimes apex bodies, e.g. in the form of a secondary cooperative, are set up to provide technical assistance (see Boxes 75, 76 and 77 in Chapter 4.3).

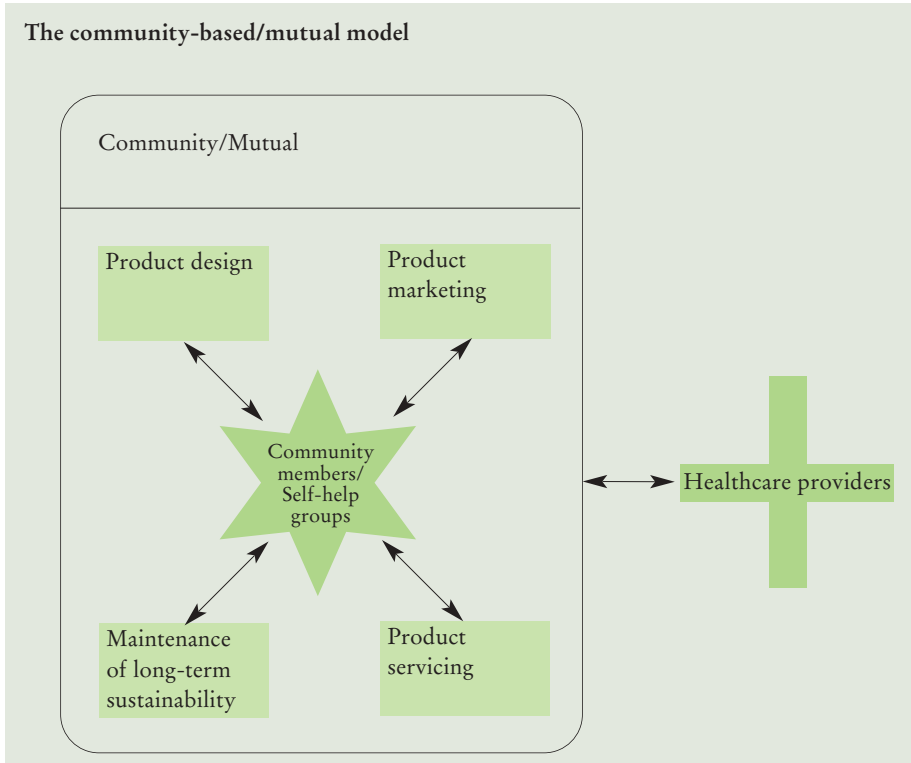
As member-run organizations, mutual benefit societies are based on the principles of self-help, self-administration and self-responsibility. According to the latter principle, the members bear the actuarial risk and are liable for potential losses. By the same token, profits remain in the system to the advantage of all members. This loss- and profit-sharing model suggests that the interest of the individual remains aligned with that of the group, strengthening social cohesion in the group. This model, especially when operated in small communities, usually lowers the costs stemming from

⁵ Mutuals, derived from the French concept of *mutuelles*, are known by many names: friendly societies in Anglo-Saxon countries (and their former colonies), fraternal societies in the United States, *Versicherungsvereine auf Gegenseitigkeit* in Germany, *sociedades de socorro mutuo* in Spain (and its former colonies), and so on.

fraud, moral hazard and adverse selection. This is due to high levels of social cohesion, which is usually more prominent in small groups, where social interactions tend to be both more important and easier to trace (Sobel, 2002), and translate (in the health microinsurance context) into an informal and frequent flow of information. However, this flow of information can create a privacy issue as well, since people might be afraid of social exclusion in case of certain illnesses – for example, in the case of HIV/AIDS and mental illnesses – and thus prefer not to rely on the benefits of the scheme.

Figure 30

The community-based/mutual model



Another drawback of such mutual schemes is their smaller group size: small groups experience greater uncertainty about claims expenses and are more vulnerable to catastrophe risk. While social control may be a suitable instrument to reduce moral hazard, successful risk spreading – or at least a transfer of accepted risks – requires merging with other risk pools or access to other forms of reinsurance. Further aggregation of risk would not only lead to increased financial stability, but also result in lower premiums through decreased capital loading (Dror et al., 2005a); however, this kind of reinsurance is usually not available.

In a member-owned institution, the responsibility for stability rests with the member-run management, which is sometimes delegated to professional managers. According to the ownership principle, all members should ideally feel committed to the stability of the system. The notion of ownership in terms of identification with the system and a sense of personal responsibility may represent a major advantage of community-based schemes. To strengthen the personal responsibility and prevent losses due to over-utilization, UMSGF has developed a “loss ratio trend tool”, bringing together statistical information to inform members and strengthen their feeling of ownership.

However, personal responsibility can easily get lost when mutual organizations grow and become more professional. In this process, the member-run administration of community-based schemes is replaced by professional managers who might develop their own set of aims rather than focus on the members’ objectives.⁶ Managers have an incentive to expand the scheme, as this might enhance their remuneration, reputation and power. Although this is good in terms of stabilizing the financial viability of the scheme, the voice of the individual insured can no longer be heard. It becomes increasingly difficult for insured members to monitor their own scheme due to information asymmetry and asymmetry in skills between the professional management and themselves. The scheme is no longer member-ruled but taken over by managers. This can result in members losing their sense of ownership, and thus in the loss of many advantages of the mutual scheme, except that profits still remain with the group of insureds.

2

Value, interests and conflicts in the insurance business process

Besides these four main types, a number of further possible subtypes exist, all with their own combinations of strengths and weaknesses. However, an analysis of these main models illustrates the key conflicts of interest that emerge in the provision of health microinsurance. In microinsurance, efficiency might be even more important than in conventional insurance, and therefore one must pay special attention to the conflicts of interest in the business process. If these conflicts remain unresolved, they add costs to the insurance arrangement. Using the framework presented in Chapter 2.1, this section considers the conflicts of interest and efficiencies in the business process of the different delivery models.

⁶ The potential conflict between members and managers is extensively discussed in cooperative literature, for example: Dülfer (1995), Vierheller (1983, 1977), Neumann (1973), Eschenburg (1972) and Hanel (1992).

2.1 Product design: Offering value for money and responding to client wishes

Health microinsurance clients generally prefer broad coverage that includes low-cost, high-probability events (e.g. outpatient coverage, pharmaceuticals), while insurers like to cover rare events. This conflict of interest is most apparent in the partner-agent model, where the main aim of the insurer is usually profit, and where less frequent claims help profit margins by keeping administrative costs low. For example, the plans offered by VimoSEWA/ICICI Lombard and Shepherd/UIIC only cover hospitalization. The health microinsurance products offered by commercial insurers typically focus on this kind of benefit.

Commercial insurers are reluctant to deal with endless numbers of small claims, especially when an arrangement with unregulated healthcare providers would produce additional monitoring costs. However, the insurer, which maintains control over product design, also finds it hard to know what the insured want: what price are clients willing to pay and for what benefits? Here, the agent can help resolve a part of the problem. The more the insurer is willing to involve the agent – on behalf of the client – in the design of the benefit package, the more likely the product is to respond to clients' needs. However, insurers may consider some low-income market segments too small to justify a costly adaptation process. Rather, the insurer will be tempted to persuade agents to sell products already developed.

The provider model would possibly be better placed to be aware of client priorities if consumption of health services were systematically registered and analysed prior to launching the insurance product, even though there is, generally speaking, little data on willingness to pay and priorities of the client. Furthermore, depending on the type of services they offer, providers might adopt a more flexible attitude to the clients' desire to have low-cost, high-probability events (e.g. outpatient care) included in the benefit package. This is usually true for charitable models as well, and can apply to community-based models too. However, the perspective in defining the benefit package is different: in provider-driven models, services are included in the benefit package only if they are actually offered by the healthcare provider. Therefore, the provider, not the client, is the starting point. Charitable and community-based insurance providers might be more likely to take the clients' needs as the starting point, as their concern is neither profit nor developing their own healthcare facility, although the charitable model might not consider it necessary to involve the community as it plans to assume the risk in any case.

The community-based model, which by definition involves the client in the benefit design process, has a strong advantage in knowledge of clients' needs and willingness to pay. The insurance product in this model is likely to respond more directly to the clients' needs and may even increase their willingness to pay. However, it has to be stressed that this strength of community-based models can only be exploited with the participation of the members, which does not always occur in practice, especially when these associations expand.

Another conflict of interest can arise in the provider-driven model when the price of services is negotiated, as the same institution represents both the purchaser and supplier of services. Although one assumes that most provider schemes use their knowledge of their own cost structure for the benefit of the client, a basic conflict of interest remains and special attention needs to be paid to it. The (partly) provider-driven Yeshasvini Trust, for example, has fixed flat rates for surgery for all 150 hospitals in the network. However, not all types of surgery are offered in each clinic, and some clinic managers claim that hospital managers participating in the administration of the trust ensure better rates for operations that are primarily carried out in their hospitals. While this may be a case of "the neighbours' grass is always greener", it is an issue that large provider networks need to sort out if they wish to increase their efficiency.

The frequency of premium payment is another area where the interests of the insurer and the insured are fundamentally different: clients often prefer small, frequent payments. This, coupled with the relatively small size of the premiums, poses a challenge to insurers. Partners, care providers, charitable insurers and community-based schemes are all likely to try to circumvent this by establishing a system where collection can be done either up-front, or through a deduction at source, or seek a third-party subsidy or advance.

However, the community-based model, the charitable insurer and agent organizations, with their access to clients, are naturally equipped to resolve this mismatch between the interests of the insurer and the insured. This is achieved by relying on existing social structures in the community and the existence of community workers who can piggyback on other interactions with the community. This makes it much easier for them to respond to requests for more frequent payment than it is for healthcare providers, which do not usually have regular contacts with the target market.

2.2 Product marketing: Trust and access required

An efficient sales process depends to a large extent on levels of trust and easy access to the clients as information exchange and client education make up the core activity in this process. The lack of a relationship of trust and access (both physical and psychological) to potential clients usually deters formal insurance companies from entering this market alone. This sits well with the philosophy behind the partner-agent model that the main responsibility for product manufacturing lies with the insurer, which then delegates distribution responsibilities to agents. From the clients' point of view, agents facilitate communities' access to insurers and providers which may otherwise be inaccessible to the clients, and provide the latter with access to a recognizable and trustworthy "brand".

In this regard, the marketing of the provider model can thus benefit from the professionalism of well-known hospitals. Many of the private hospitals associated with Yeshasvini Trust enjoy an excellent reputation. The Narayana Hrudayalaya hospital in Bangalore, for instance, is well reputed for cardiac surgery even beyond Karnataka state. The participation of hospitals like this is positively received by many insured members who otherwise would have difficulty accessing these quality care providers.

However, clients' trust in the organization that carries out the actual sales process is of even greater importance, and while insurance companies lack this relationship of trust, agents (in the form of local organizations like NGOs) usually have more respectability and thus ability to reach potential clients. Community-based schemes, as their name implies, are in constant contact with their members and are likely to have far greater levels of trust and access to them than many other organizations. As a result, the cost of informing members about the benefits of health insurance decreases, and the likelihood of a sale increases.

2.3 Product servicing: Managing the flow of information

On the whole, the interests of the different insurers are aligned in the servicing area. All would like an efficient system that would keep costs down and reduce fraud. A cashless system is usually best for achieving these goals, and has the added advantage for the insured of not having to advance money to get treatment. In the partner-agent and community-based model, a cashless system has the additional benefit of enabling the risk carrier to negotiate with healthcare suppliers to bring costs down. Not surprisingly, this negotiation does not take place in the provider-driven model, which effectively limits competition and could result in higher prices or lower service quality.

However, many insurance companies are unable or unwilling to negotiate and set up a relationship with a tight network of rural doctors or hospitals as they find it difficult to control the appropriateness of services rendered and claims filed. To obtain the information they require for verifying a claim without having to negotiate with an additional party (the provider), some insurance companies settle claims on a reimbursement basis only. This arrangement places a heavy burden on poor households. Due to complicated and inappropriate paper work, exclusions, and procedures required by the insurance companies, reimbursement is often delayed, sometimes for months.

Provider-driven insurers, community-based schemes and most charitable insurers are better placed in this respect. Due to their local presence, they can offer benefits in kind more easily – especially in a provider scheme. Their claim verification process is usually better adapted to local circumstances as well. This helps to keep clients satisfied and thus results in higher renewal rates and increased willingness to pay, and probably promotes equity.

2.4 Securing long-term sustainability

Just as the insured pay little attention to probabilities, they also tend to discount other technical aspects related to the provision of insurance, such as the need to pool risks (law of large numbers), the need to invest for the future, or the effects of a particularly high claim load in a current year on premiums (or even insurance availability altogether) for a future year. Nonetheless, the insured expect the insurance provider to meet all its liabilities and constantly reduce their losses.

This conflict poses considerable difficulties for all insurers, but it is a particular challenge for community-based schemes for two main reasons. Firstly, members are likely to exercise greater control over scheme decisions in a community-based model than in any other model. Therefore, in a year with relatively few claims, members might attempt to force the scheme to redistribute unused reserves or to increase benefits, which would pose a danger for long-term sustainability. Secondly, community-based schemes might not have the risk management expertise on hand, and are more likely to assess the actuarial risk incorrectly. While reinsurance can help resolve both of these problems, the fact remains that a stand-alone community-based model is likely to be most vulnerable as regards long-term sustainability (besides the charitable model which relies on indefinite subsidies).

To summarize, the basic incentive structures of the four models are captured in Table 45. In the last row of the table, the main conflicts of interest between different stakeholders are articulated for each model.

Table 45

Basic motivations and primary interest through the business process

	<i>Partner-agent</i>	<i>Charitable insurer</i>	<i>Provider</i>	<i>Community</i>
<i>Basic motivation</i>	Profit (for the insurer); coverage for the target group (for the agent)	Reduce the long-term cost of health risks for target group	Generate business and increase access to (own) services	Reduce the long-term cost of health risks for members
<i>Manufacturing</i>	Rare events that represent fewer, larger claims to keep transaction costs low	Responding to clients needs as well as possible	Benefit package designed with view on own services offered	Optimal balance between benefits and premium for the members
<i>Sales</i>	Use of agents (e.g. MFIs) to enhance proximity and ease of payment	Use of existing community structures (e.g. SHG, NGOs, etc.) to keep costs low	Distribute among potential patients as long as number can be serviced in facility	Use of existing community structures (e.g. woman's associations) and involvement of members
<i>Servicing</i>	Reduce fraud (e.g. with cashless systems) and negotiate on scale with supplier to drive down costs	Reduce fraud (e.g. with cashless systems) and negotiate on scale with supplier to drive down costs	Reduce fraud (e.g. with cashless systems) and negotiate on scale with supplier to drive down costs	Reduce fraud (e.g. with cashless systems) and negotiate on scale with supplier to drive down costs
<i>Sustainability</i>	Price products correctly, achieve a sufficiently large group size and risk diversification, while maintaining high renewal rates	Price products correctly, achieve a sufficiently large group size and risk diversification, while keeping high renewal rates	Achieve high renewal rates, sustain desired client group for services that have excess capacity	Price products correctly, achieve a sufficiently large group size and risk diversification, while maintaining high renewal rates; prevent members from divesting reserves from future years

	<i>Partner-agent</i>	<i>Charitable insurer</i>	<i>Provider</i>	<i>Community</i>
<i>Main conflicts of interest</i>	<p>Insurer-agent: Agents usually regard themselves as advocates of the insured rather than the insurer, though their financial incentives are aligned with those of the insurer</p> <p>Client-insurer: Feel that money is lost to a big and distant company if not claimed at least once a year</p> <p>Insurer-client: Profit motive of the insurer might drive the premiums up</p> <p>Insurer-client: Investor-owned risk capital in microinsurance results in high expectations of return on the part of the shareholder</p>	<p>Insurer-client: The paternalistic and social characteristics of the charitable model might favour health objectives of donors/NGO management over clients' preferences</p> <p>Insurer-client: Where dependent on donor funding, it may not reduce the real long-term cost of risk for the client</p> <p>Client-insurer: Expect services to be provided regardless of whether their cost is sustainable or not</p>	<p>Insurer-client: Interest in good utilization of facility and thus includes (only) own services in the benefit package. This might result in benefit packages being too narrow for effective risk protection for target group</p>	<p>Manager-members: Tempting for managers to enlarge the insurance scheme, but this often does not benefit the members. With growing size of the insurance scheme, managers tend to lose focus on the members and members rarely have the skills to control them effectively</p> <p>Field staff-insured: Field staff are usually taken from the group of insured; social inequalities within the group of insured might lead to unequal treatment of insureds. Some might be persuaded not to use services for the sake of stability of the entire scheme</p>

3

Conclusion

This chapter reviews a basic typology of health microinsurance providers based on an examination of their primary motives and underlying business processes. One interesting issue can be highlighted by asking a simple question: whose interest is served if an insured (client) claims benefits? Obviously, the individual claiming can be assumed to gain, but what about the different insurance providers?

It can be argued that charitable organizations, and to an extent provider-driven organizations, would see a utilization of health services as a positive outcome. However, under the partner-agent model, the partner would have an incentive to discourage claims (ideally through good health, although complex claim requirements could be an alternative). Indeed, in schemes where insureds only receive benefits if they are sick (or rather, when they claim successfully), the incentive structure could be seen as encouraging false or unnecessary claims. The partner-agent is the primary example of this incentive conflict, and this additional risk therefore needs to be considered when designing business processes.

Other models would also, from an insurance business perspective, prefer to have fewer individuals claiming, but (and this is an important nuance) the primary focus would be on the good health of the clients, at least in theory. In practice, in community-based schemes, more powerful members may try to exert influence on the benefit package design or try to persuade other members not to claim in order to keep claim costs low. Inequalities in the social structure of communities have to be closely examined and taken into account.

Another important point is whether the scheme operates under a for-profit or non-profit paradigm. In the provider-driven model, for example, if the hospital is running a for-profit scheme, then it would share many of the characteristics of the partner-agent model and would have an interest in fewer claims and more profits. However, if the provider is running a non-profit insurance scheme, whereby surpluses remain within the scheme, then it would have an interest in increasing utilization, which would in turn increase consumption of its own health services (and thereby its “profitability”), up to a certain level of utilization. Once demand for services exceeds the provider’s capacity, it would also have an incentive to reduce consumption, usually through a long waiting period for insured events (which may be shortened or eliminated in cases where the insured is willing to pay extra for the service).

The community-based model reverses this incentive structure by keeping the unclaimed sums at the disposal of the group. Furthermore, through judicious use of social capital (particularly through peer monitoring in member selection and claims processing), the community-based model reduces adverse selection and moral hazard – but only if it is truly participatory and members take over ownership. Therefore, if its long-term sustainability can be assured, it seems that the community-based model has a number of advantages in health microinsurance provision, as it has better information on (and contact with) its clients, far less scope for conflicts of interest, and better mechanisms to mitigate adverse selection and moral hazard.

It would be naive to assume that one model combines all advantages and no disadvantages. All models need to learn from each other to achieve an optimal business process. The partner-agent-model, for instance, is strengthened considerably when it integrates features of the community-based scheme, such as involving the target group in designing the benefit package, or introducing a profit-sharing arrangement in good years. In a similar vein, the community-based model can learn from professional insurers, notably on how to resolve technical and sustainability problems (including access to reinsurance, which would not only add to financial stability, but can help in acquiring the technical resources necessary for running a viable business).

Health microinsurance is a different animal from insurance for the formal sector, and what works well for high-net-worth clients is not easily replicable for informal and rural communities. While health microinsurance holds much promise, the question of appropriate institutional options and channels for its delivery will need to be looked at closely by academics and practitioners. If this question is overlooked, then the very concept of health microinsurance could be tainted as inefficient due to inadequate provision models.

Beyond MFIs and community-based models: Institutional alternatives

Richard Leftley and James Roth¹

The authors wish to thank Vijay Athreya (Tata-AIG), Doubell Chamberlain (Genesis) and Jeremy Leach (FinMark Trust) for their useful comments and suggestions.

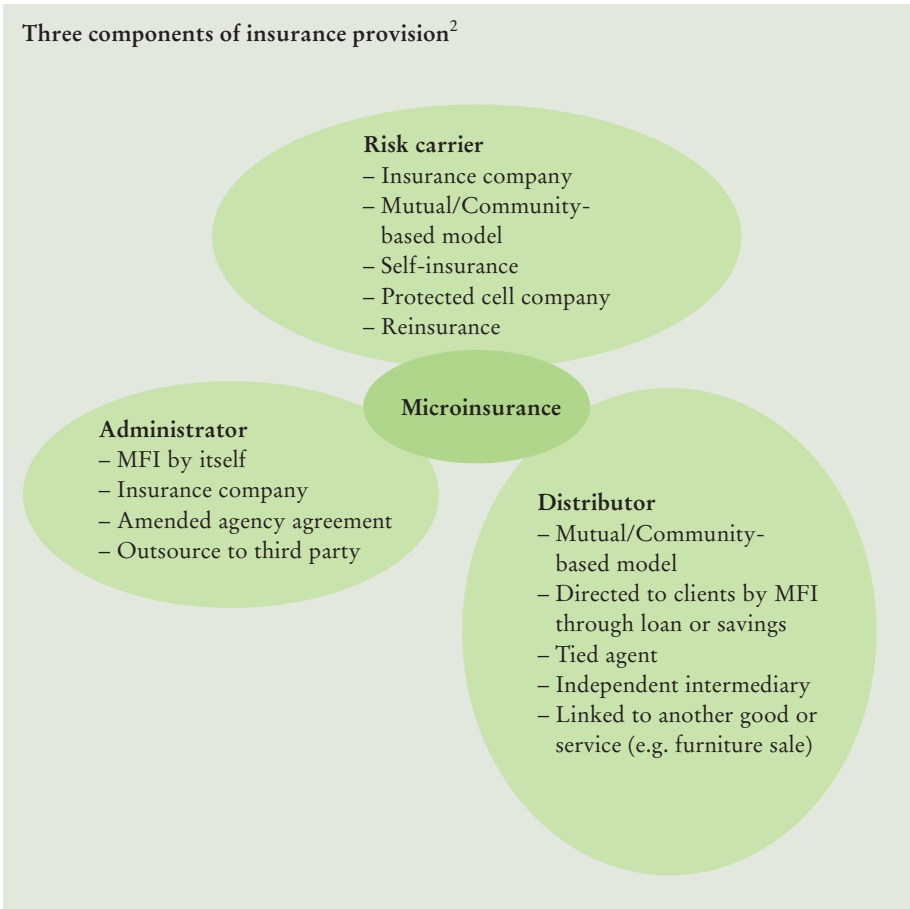
For the most part, insurance for the low-income market is a high-volume, low-premium business. There are instances where microinsurance clients are more concerned about quality than price, for example funeral insurance in South Africa, but on the whole the low-income market is deeply price-sensitive. Keeping costs low is therefore a necessary requirement to attract customers and make the business sustainable.

As discussed in the previous chapters, in many circumstances the partner-agent, the cooperative or the community-based models will provide suitable solutions. The partner-agent and co-op models build on established distribution networks (e.g. an MFI or credit union) that already provide financial services to the poor, so insurance is simply added to an existing channel for a marginal cost. With the community-based model, which is managed by the policyholders themselves, costs are minimized by the reliance on volunteer labour and leveraging social capital to control insurance risks. These are not, however, the only microinsurance models.

This chapter explores other institutional options for the provision of insurance to the poor. In an insurance structure, someone has to 1) carry the risk, 2) administer the product and 3) handle the distribution (*see Figure 3.1*). These functions could all be performed by one organization (e.g. the direct sales approach at Delta Life in Bangladesh), or they each could be managed by different organizations, or some combination of the above. By using this framework to break provision down into three definable segments – risk carrier, administrator and distributor – this chapter considers the range of alternative arrangements for providing microinsurance. The chapter looks at where the various options are appropriate and how they would decrease cost and/or enhance the product quality.

¹ References to the Micro Insurance Agency are drawn from the authors' experiences.

Figure 3.1

Three components of insurance provision²**I Risk-carrying alternatives**

While most risk carriers are regulated insurance companies, there are alternative ways of underwriting risk. This section considers both self-insurance and protected cell companies.

I.1 Self-insurance³

Perhaps the most commonly considered alternative for carrying risk is self-insuring, where an unlicensed and unregulated organization offers its own insurance product. This option is employed by TYM (Viet Nam), MUSCCO (Malawi), AssEF (Benin) and Spandana (India); many other organizations

² The authors wish to thank Jeremy Leach for providing them with this framework.

³ The term “self-insurance” is used differently in this chapter from in Chapter 1.2. In Chapter 1.2, self-insurance refers to ways in which low-income households cope with losses by carrying the risk themselves, for example by covering the costs from savings or liquidating assets. In this chapter, and in Chapter 4.7, the concept of self-insurance is applied at an institution level – that is informal, unregulated insurance schemes that carry the risks for their members.

have tried self-insurance, but have ultimately reverted to the partner-agent approach, including SEWA and ASA in India.

Self-insurance is often outside the legal framework. While many insurance supervisors are willing to look the other way, the schemes usually operate in a grey area, vulnerable to political changes. Most self-insurers do not have access to the actuarial expertise required to calculate premiums or reserves. As unregulated insurers, these organizations are unable to purchase reinsurance to reduce their potential losses in the event of catastrophes. Indeed, as discussed in Chapter 4.7, if organizations want to self-insure, one of the preconditions will be some way of dealing with covariant risks other than just excluding them.

Self-insuring organizations often offer poorly priced products that either provide poor value for money to clients or lose money for the organization selling it. Organizations that do manage to calculate a rate that generates a profit are often unable to avoid the temptation of raiding the pot at the end of the financial year. The result is that no reserve is built up for “incurred but not reported” (IBNR) losses or to cover potential future losses arising from catastrophes, such as natural disasters or disease epidemics.

Reserves are particularly important for organizations that are unable to secure reinsurance. Even if reinsurance is available to an informal self-insurer, reserves are still needed because reinsurers will not offer coverage that guarantees a breakeven or profit. If the reinsurance is placed on a proportional basis (e.g. quota share or surplus treaty), then the treaty will be arranged so as to leave the primary risk carrier with some retained risk; otherwise a moral hazard problem arises whereby the primary insurer has no motivation to ensure the quality of the business or validity of claims. If the reinsurance is placed on a non-proportional basis (e.g. excess of loss treaty), then reserves will be required to cover the retention as well as the losses that exceed the treaty (*see Chapter 5.4 for more details on reinsurance*).⁴

1.2 Protected cell company

The self-insuring option has some significant limitations; but there will be instances where a required product is simply not available from a regulated risk carrier. In cases where a microinsurance product is not available, the pricing is disadvantageous for the client, or the required level of customer

⁴ An excess of loss treaty can be exceeded in two ways: 1) vertically, whereby the accumulated loss exceeds the value of the cover that would be purchased on the basis of the “probable maximum loss” or PML, or 2) from a series of losses that exceed the sideways cover afforded by the limited reinstatements of the lower layers of the programme.

service is deemed to be lower than what the market expects, then a protected cell company (PCC) could be a viable option.

A PCC transacts insurance using the host insurance company's capital and regulatory status. Policies are issued in the name of the insurance company. The contract drawn up between the host insurance company and the PCC's owner stipulates, among other things, that a management fee will be paid to the host by the owner as a "rental" for the licence required to transact insurance.

The PCC's owner is entitled to determine the terms and conditions of the insurance products that are provided to its clients. The owner can determine the pricing of any product as well as the service standard, for example the speed of claims payment. At the end of the year, any profit or loss is the responsibility of the owner. If the products are incorrectly priced then the protected cell company would end up having to fund the loss. In most cases, the host would help the owner to purchase stop-loss reinsurance so as to limit the financial cost of any underwriting loss.

To date there has been very limited evidence of microinsurers using PCCs as a method of carrying risk (*see Box 81 for an example of an aborted attempt*).

Box 81

Zambuko Trust, Zimbabwe

In April 2003, Zambuko Trust, a microfinance NGO in Zimbabwe, was seeking to develop a funeral insurance product with technical assistance from Opportunity International. The customer-needs analysis showed that clients expected claims to be paid within 24 hours. This requirement had arisen because many clients participate in informal burial societies, which often pay claims within hours.

While a range of regulated insurance companies were willing to provide a suitable funeral product for Zambuko's clients; none of them could pay claims so quickly. The management of Zambuko believed that in order to compete with informal providers, claims payment within 24 hours was an essential product feature. The only alternative was to seek to gain control over the product and hence the service provided to clients.

After some negotiation, one insurance company was willing to host a "protected cell company" owned and managed by Zambuko Trust. Ultimately, however, the management of Zambuko decided that due to the economic situation and rapid inflation in Zimbabwe, pricing of the insurance products would be difficult and the risks associated with the venture were too high, so the initiative never got off the ground.

Source: Adapted from Leftley, 2005.

The protective cell company is essentially a legal way of self-insuring. By writing policies on an insurer's licence, it is also possible to tap into the expertise of a friendly insurance company that may assist in establishing reinsurance cover. Like self-insurance, the most significant downside is that any underwriting loss must be funded by the PCC's owner. In addition, the owner must have access to insurance expertise on a regular basis to manage the PCC and establish suitable products and rates. Another disadvantage is that it may be difficult to set up unless the owner has a close and trusting relationship with a prospective host. Furthermore, if the product to be sold is already available from the insurance company then there will be little incentive for it to offer a PCC structure as it would be more profitable for the insurance company to utilize the owner as a distribution channel and carry the risk itself (i.e. the partner-agent model).

2 Administrative alternatives

Typically the work load associated with the administration of insurance products can be broken down into two key stages: firstly, there is policy formation, where the client completes an application form and pays a premium and secondly, there is a claims process where details of a loss need to be recorded and the benefit paid to the claimant.

The procedures relating to premium collection (*Chapter 3.3*) and claims administration (*Chapter 3.4*) are covered elsewhere in this book; this section considers two alternatives for conducting this administration: amended agency agreements and third-party administrators. By way of comparison, it is broadly true that for those operating according to the partner-agent model, policy formation and premium collection are carried out by the agent (such as an MFI), and the claims administration is performed jointly, with the agent collecting the claims documentation and the partner (insurance carrier) verifying and paying the claim.

2.1 Amended agency agreements

A crucial element of an insurance product for a low-income policyholder is the speed at which claims are paid. In the partner-agent model, while the agent may inform clients about the involvement of an insurance company, it is quite common for clients to blame the agent's field staff when claims are delayed. Even when insurance companies take steps to reduce the waiting times for claims payment, it often takes a few weeks to process a claim. When this processing time is added to the time that it can take for a client to gather

the required claims documentation and for the MFI to perform its own administration, months may pass from the occurrence of the insured event to the claims settlement.

In many organizations, this delay has caused considerable client dissatisfaction. To overcome the problem, several MFI agents have sought to amend their agency agreements so that they assume responsibility for managing claims. While this is a modification to the standard partner-agent model and not an institutional alternative, it is worthy of mention as it shifts key tasks, namely verifying and paying claims, from the insurer to the MFI.

For example, CETZAM pioneered funeral microinsurance in Zambia by collaborating with NICO Insurance in 2001 to provide the Ntula Funeral Insurance product. By May 2002, it was clear from market research that claims payments were taking too long, and as a result NICO was asked to consider amending the agency agreement.

It was agreed that CETZAM would pay the claims it considered to be valid. The documents that supported the claims would be submitted along with the monthly premium report and premium payment (net claims paid) and NICO would check the documents to ensure that they agreed with the claims that had been paid. If CETZAM paid an unjustified claim, then NICO would demand repayment of the claim value; to date no claims have been refuted by NICO. The claims settlement period fell from two months to less than two weeks as a result of this agreement.

An amended agency agreement is a way to improve the partner-agent model. It is particularly appropriate for life insurance, since the applicable insured event is easy to verify and hard to fake. For other risks, additional training may be required for the agent's field staff to know how to verify claims. For example, staff will have to learn how to distinguish between accidental and natural deaths if they result in different benefits. In India, VimoSEWA has developed such expertise in verifying claims that its insurance partners allow it to pay health and property claims (*see Box 82*).

Box 82

VimoSEWA's claims committee

During a period when VimoSEWA managed its own insurance fund, the organization brought in an insurance claims expert to establish protocols, form a claims committee and train staff. When VimoSEWA reverted back to the partner-agent model in 2002, it negotiated with its insurance partners to allow it to continue paying claims.

VimoSEWA has an eight-person claims committee, consisting of head office staff, insurance field agents (*Vimo Aagewans*) and field workers (*Aagewans*) from SEWA's health, union, childcare and bank teams. The committee meets three times a week and a doctor attends the committee if there are complicated health claims. He also assists the committee by imparting information on diseases and medical terms.

Representation of various *Aagewans* is essential for fair claim settlement practice. It helps the committee gain knowledge on insurance practices, and they carry the message of unbiased claim settlement to their members and teams. Occasionally, the insurers reject a claim that the committee feels should be paid, but VimoSEWA assumes the liability for these extra-contractual claims. The claims committee plays an important role in detecting fraud and moral hazard. The physician is particularly helpful in assessing which caregivers are providing expensive or unnecessary treatment.

Source: Adapted from Garand, 2005.

2.2 Outsourcing to TPAs

It is common practice for insurance companies, particularly those involved in health insurance, to outsource the administrative work to a third-party administrator (TPA). There are, however, few instances of this outsourcing among microinsurance schemes, largely because simple products like credit life are relatively easy and cheap to administer, so they rarely motivate management to consider the costs and benefits of outsourcing some or all of the administration.

For health insurance, the case for outsourcing needs to be assessed. Health insurance typically involves a relationship with a health service provider. This relationship, among other factors, introduces costs and new administrative burdens, such as ensuring that the health provider is not defrauding the scheme. Health insurance schemes often outsource part of their administrative operations to a professional TPA. By specializing, TPAs are often able to lower the overall administrative costs.

Third-party administrators are fairly common in South Africa where local insurance companies use them to administer funeral insurance – indeed some administrators have developed such large client bases that they themselves have become insurance companies. The TPAs purchase insurance cover in bulk from the insurance company and retail it to individual clients or groups of clients at a price that may be much higher than the price they paid to the insurance company (though it should be noted that the administrators are often able to provide access at a lower price than that charged by insurers through their normal distribution channels). The policies are issued

in the name of the insurance company. The TPA is authorized to verify and pay all claims on behalf of the insurance company without supervision from the insurance company, which can lead to extremes of either fraud or refusal to pay claims. As a result, a section of the TPA market in South Africa has an increasingly tarnished image with consumers, the insurance companies and regulators.

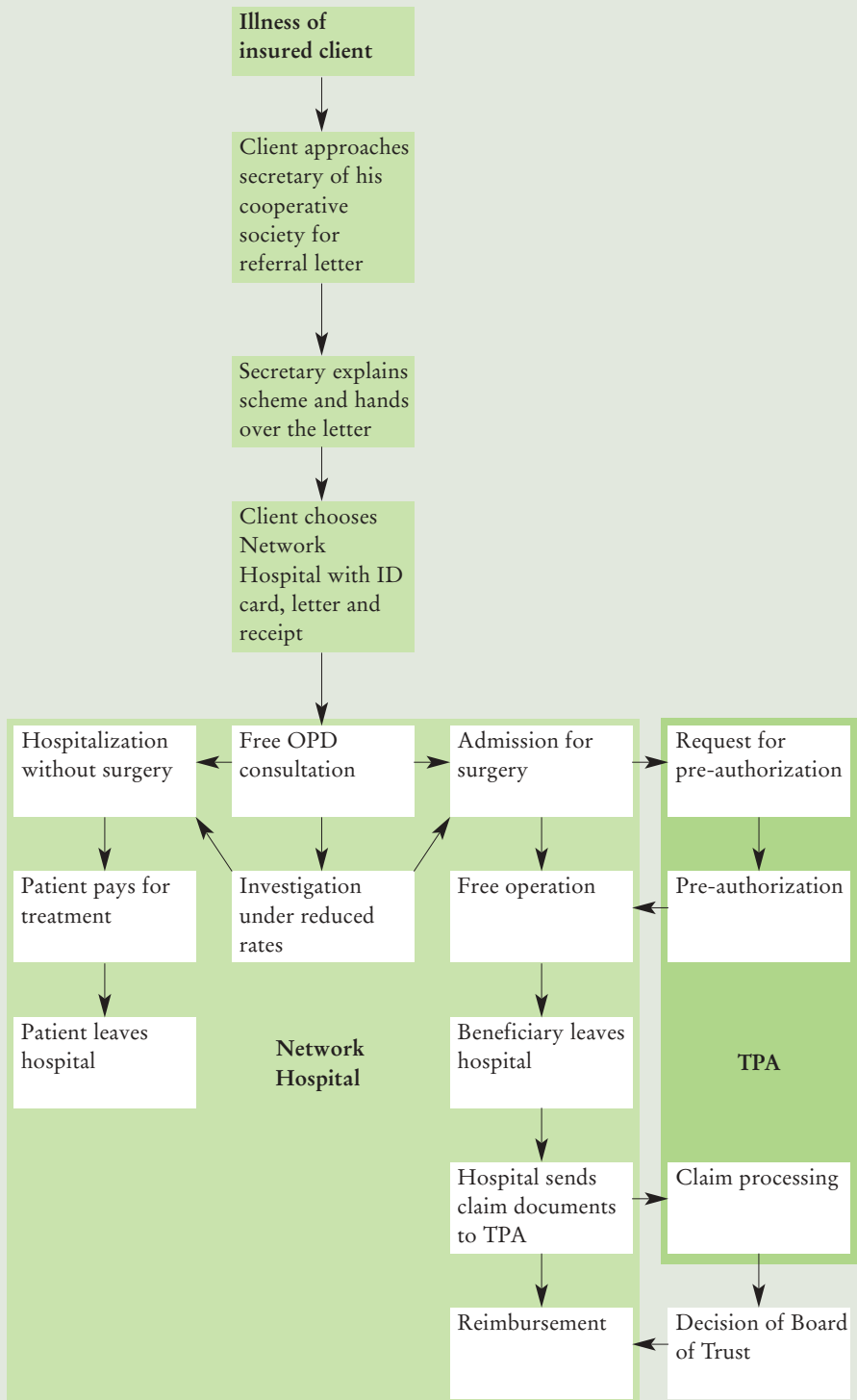
Yeshasvini Trust, a health microinsurance scheme in India, decided to outsource its administrative functions to a TPA. The Yeshasvini Trust offers insurance to cover high-cost, low-frequency surgery for as little as Rs. 120 (US\$2.70) per year for a maximum cover (per person per year) of Rs. 200,000 (US\$4,545). To help the scheme manage its 1.45 million members, Yeshasvini developed a relationship with a private TPA, the Family Health Plan Limited (FHPL), which also administers insurance schemes for the police in the southern states of Karnataka and Andhra Pradesh. The TPA assumes the following tasks:

- Maintaining a register of the insured clients
- Authorizing treatment
- Issuing ID cards to members
- Preparation of claim settlement including verification
- Preparing reports and statistics
- Managing the funds

FHPL plays a critical role as the gate-keeper for approving surgery and then paying the hospital, so policyholders requiring surgery have no out-of-pocket healthcare expenses (*see Figure 32*). This arrangement is not without difficulties. While outsourcing can increase efficiency, the addition of an extra institution can also add complexity. Sometimes it takes FHPL four or five days to authorize surgery, and occasionally reimbursements to the healthcare providers are also delayed. In general, however, the arrangement of having specialized agencies focusing on their areas of expertise makes sense, especially when dealing with such huge volumes of policyholders accessing services from more than 150 healthcare facilities.

Figure 32

Yeshasvini's claim settlement process



Source: Radermacher et al., 2005b.

In terms of the costs, FHPL and Yeshasvini Trust negotiated payment of Rs. 7 million (US\$159,000) in Year 1 and Rs. 4 million (US\$90,900) in Years 2 and 3. Since these fees are equivalent to 2 to 3 per cent of premiums over the past two years, this seems like a very affordable solution for Yeshasvini. According to Radermacher et al. (2005b), FHPL claims to implement the scheme on a non-profit basis because it provides it with experience in serving the market at “the bottom of the pyramid”.

3

Distribution alternatives

Many clients who currently purchase microinsurance have gained access through financial organizations with which they have an existing loan or savings account. Even though this institutional arrangement has significantly reduced the transaction costs associated with providing insurance, it has limitations because clients can only gain access to insurance when they have an active loan or a savings account.

In principal, there are a multitude of options that could be used to distribute insurance products to low-income households, including:

- *Retailers* – for example supermarkets that collect premiums at the checkout counter
- *Workers’ unions and cooperatives* – premiums could be deducted from dues
- *TV/direct sales* – advertise products directly to the customer with telephone operators standing by
- *Cell phones* – using the cell phone infrastructure to gather premium payments
- *Burial societies and ROSCAs* – use the informal societies to sell a regulated product
- *Worksite marketers* – sell products to low-income workers during lunch breaks

While these channels may work in developed countries, many developing countries do not have sufficient infrastructure or levels of client education to implement such distribution methods. So what alternative forms of distribution have been used to deliver microinsurance? Besides partnerships with retailers, which are discussed in detail in the next chapter, this chapter considers the role of microinsurance agents and independent microinsurance intermediaries.

3.1

Microinsurance agents

Tata-AIG in India has developed a system of micro-agents to deliver term and endowment policies to the low-income market. In this model, the insurer identifies NGOs that have a good relationship with the community and develops partnerships with them. In return for a consulting fee, the NGOs suggest persons who could be good agents to sell microinsurance policies: the micro-agents. If these recommended micro-agents are accepted, they are then asked to form groups of peers.

The group, referred to in the Tata-AIG model as a Community Rural Insurance Group (CRIG), consists of five low-income women living in close proximity, of whom the leader is licensed as an agent. The CRIG is registered as a partnership firm. The CRIG members are typically women because they tend to work with, and come from, self-help groups (SHGs) whose members are usually women. While not the only target market, the SHGs represent an easy way to reach large numbers of potential policyholders because the members are already accessing financial services and making regular payments.

Tata-AIG helps the group leader obtain an agent's licence, which requires an investment in training the individual. Thereafter the CRIG, as a statutory enterprise, obtains a corporate agent's licence under the insurance regulator's guidelines. The members of the group all sell policies for their own account, but the leader with the agent's licence fills in the forms and submits the policies to the company under the guidance of the NGO. In return for this task, the NGO receives an additional commission percentage from Tata-AIG.

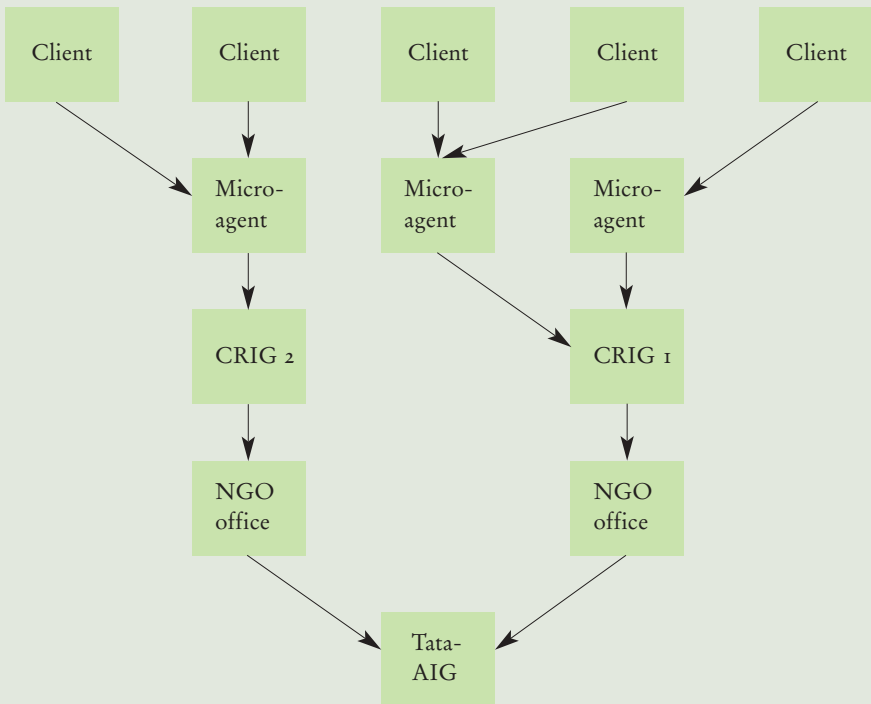
In addition to the group approach, where getting five like-minded, somewhat educated women to start a firm can be difficult, Tata-AIG uses individual micro-agents. Like the CRIGs, individual micro-agents tend to be women (though some are also men) who are either involved in an SHG or voluntary workers of an NGO. After being certified, micro-agents are encouraged to acquire clients in the vicinity of their homes, which may extend to surrounding villages.

The advantage of a CRIG over individual micro-agents is that only one in five agents needs to be licensed, which lowers start-up costs. The group can also structure responsibilities in ways that suit the expertise of the individuals; for example, some people may be better at selling and others may be better at collecting premiums. If a CRIG member is sick or travelling, or chooses to stop working as an agent, other CRIG members can fill in accordingly. This leads to better management of orphaned policies. In the long run, once fully functional, the CRIG can also be linked to other marketing organizations to distribute non-competing products and services and enhance their income.

In this model, the NGO carries out a variety of tasks including aggregating premiums and sending them on to Tata-AIG (see Figure 33), allowing the agents to use their offices to conduct business, playing a role in the training of micro-agents and helping in the assembly of claim documentation and the distribution of claim benefits. The model thus has an additional positive spin-off in that it provides a new income stream for rural NGOs and micro-agents.

Figure 33

Micro-agents, CRIGs and NGOs in the premium-collection process



Source: Roth and Athreya, 2005.

This distribution method is similar to the direct-marketing model of firms such as Tupperware and Avon, where salespersons work on a part-time or occasional basis selling to their family, friends and neighbours. For the agents, this type of work is particularly appropriate as a supplementary income source. Generally, the CRIG commission per policy is 26 to 30 per cent of the premium for the first year, and between 5.5 and 6 per cent for the second and third years. From the fourth year onwards commissions vary between 4 and 5 per cent.

Tata-AIG has not assessed what percentage of the micro-agents' livelihood is provided by their insurance work, although the monthly income earned by CRIG members ranges from Rs. 55 (US\$1.20) to Rs. 2,487 (US\$55.26), with an average of Rs. 665 (US\$14.78). It is estimated that micro-agents could earn at least US\$15 per month over 15 years, if they sell 250 policies in 2 years, and then service the policies for the full term of 15 years. The earnings are larger in the first two years because the commissions are front-loaded. However, in the third year micro-agents are trained to enhance their incomes by focusing on sales of higher premium products, so they could earn significantly more than US\$15 per month if they succeed with the wealthier market.

Even though the insurer does not incur any fixed costs (e.g. salaries and benefits) for its agents, the micro-agent model can still be an expensive way to deliver insurance. The cost of training and supporting agents is quite high in relation to the premium values. Although initial transaction costs are low for the agents, after they have sold policies to all the people they know and need to sell to strangers, it can become much more expensive and difficult, especially to reach people living far away.

3.2 Independent microinsurance intermediaries

Unlike Tata-AIG's microinsurance agents, there is an increasing role for microinsurance intermediaries that are independent of a single insurance company. An independent intermediary could be a corporate or individual partnership structure, working on either a local or global scale, that collaborates with a risk carrier (probably an insurance company).

While the agents discussed above work on behalf of a single insurance company, a broker works for multiple insurers. To reach the low-income market, the broker seeks to service large groups of clients through aggregators. The most suitable aggregators of low-income persons have an existing financial structure such as MFIs, rural banks and credit unions. However, groupings such as cooperatives, unions and even religious organizations, can also be targeted. The benefits of the intermediary are as follows:

1. Product development

Existing partner-agent models often place the product design in the hands of the risk carrier, which is not ideal. An intermediary that understands the needs of clients, the operational realities of the aggregator and the needs of the insurance company should be able to design a product that is more suitable for all parties.

2. Transaction costs

It is not cost-effective for an individual aggregator to develop its own MIS for transacting insurance business. An intermediary with a wider client base benefits from economies of scale which justify such an overhead. Investment in systems reduces transaction costs and increases operating efficiency by serving a much larger client base than a single aggregator can reach.

3. Administration

An intermediary is well-placed to handle administration relating to claims processing as well as reporting to the insurance company who is covered and the premiums due.

4. Additional channels of sale

Aggregators are often unable to offer insurance to persons who are not using their credit services. An intermediary brings the capability to track clients and record the premiums paid, even when a loan is not in place.

5. Staff training

An intermediary is well placed to provide organizations' staff with the required training. This increases financial literacy and, ultimately, client satisfaction.

In November 2005, Opportunity International established such an intermediary, the Micro Insurance Agency. Its first subsidiary was opened in Uganda in January 2006 to work as an intermediary for Microcare Insurance Company. Its initial product range has been targeted at the microfinance institutions and is based around a package of credit life, funeral, disability and property coverage. There are plans to introduce healthcare products later in 2006 as well as subsidiaries in Ghana, South Africa and the Philippines.

Besides targeting microfinance clients, the Micro Insurance Agency plans to sell products to client groups served by unions, cooperatives and religious organizations. To reduce transaction costs, Opportunity International has developed its own AIMS software (Automated Insurance Management System).

4

Conclusions

There are three essential institutional elements for insurance provision: risk carrier, administrator and distributor. Within each of these categories, multiple options could be used to serve low-income communities. By thinking outside the industry's current collective experience, it should be possible to combine the options into new and innovative ways of providing microinsurance. In addition, by being flexible with the tasks of different entities, it should be possible to reduce transaction costs and provide better products.

Clearly the options in the risk-carrier category are restricted and in the majority of cases utilizing a registered insurance company will remain the most likely outcome. MFIs seem to face increasing levels of regulation brought about by heightened government interest in the sector. This regulatory burden makes self-insurance more difficult and unwise; no microfinance bank wants to face closure as a result of breaching local insurance regulations. The remaining potential risk-carrying alternative is the protected cell company, yet PCCs are rare outside South Africa and Brazil. Perhaps donors and industry practitioners should investigate further the reasons for this and the potential for developing the protected cell as a risk-carrying alternative.

To date, the majority of microinsurance has been distributed and administered by MFIs. While these organizations provide the necessary scale to make insurance sustainable, the breadth and depth of products that can realistically be provided via MFIs is limited. If microinsurance is to achieve its full potential, then it needs to diversify distribution and administration to include other organizations that engage in financial transactions with the low-income market. Certainly, amended agency agreements are important in providing higher levels of customer service (e.g. speed of claims payment), but other administrative options should be explored in the future. For example, third-party administrators have demonstrated that they can significantly decrease transaction costs across all lines of business.

Of course, the major factor affecting the distribution and administration of microinsurance products is the small margins which can be earned. With premiums in the range of a few dollars, the remuneration received by a TPA or an insurance intermediary per policy is extremely small. This is a major reason for the lack of microinsurance agents. To significantly scale up the low-income market's access to insurance, there is a strong case for donors teaming up with industry pioneers to find new ways to distribute and administer products, which will lead to a wider range of products being available to more low-income people.

James Roth and Doubell Chamberlain¹

The authors appreciate the insights and suggestions provided by Vijay Athreya (Tata-AIG), Jeremy Leach (FinMark Trust) and Marc Nabeth (consultant).

While much of the microinsurance discussion has focused on MFIs or cooperatives as distributors of microinsurance, some insurers have begun to explore new distribution channels to reach the low-income market. Many are turning their attention to retailers, companies that sell goods and services other than financial services to poor households. They include grocery stores, household goods shops, transport providers, funeral parlours, cell phone shops, post offices, petrol stations, agricultural input suppliers and estate agents selling low-cost housing. In some cases, the process is being led by retailers who want to add additional services to their product lines; in other cases, insurers (often compelled by legislation or more subtly persuaded by the state) are looking at ways to reach the poor.

This chapter begins by considering the preconditions that need to be in place, for the insurer and the retailer, for this model to be effective. It then considers the types of microinsurance distribution model/products combinations that have been offered by retailers, largely based on the experiences in South Africa. The experiences suggest that for particular products, retailers could be an effective distribution channel for the low-income market, but current models still face challenges in unlocking this potential.

I Why retailers? Which retailers?

There are a variety of reasons why the distribution of microinsurance products through retailers is of interest. Retailers often have a more extensive distribution network than that of dedicated financial service providers. They can reach a larger market. People not interested in savings or loans may be interested in buying food, fertilizer or furniture. By (potentially) reaching a

¹ This chapter is based largely on the results of a consulting report commissioned by the FinMark Trust (Chamberlain et al., 2006). South African examples without citations are drawn from that source. Rand/Dollar conversions are based on the average exchange rate for December 2005 (R6.35 = US\$1).

larger market, this network can distribute products at a lower (shared) cost than dedicated financial service providers. Many retailers have established a visible and trusted presence among lower-income households, creating an opportunity for distributing other, possibly more complex, products such as insurance, for which trust is essential.

Evidence from models developing across the globe suggests that participating retailers and the insurance companies have to have a number of characteristics for retailer distribution to be successful:

- Retailers need to have **regular transactions with low-income persons** so that premium collection can be layered on top of an existing transaction. This requirement assumes that low-income persons are unlikely to make a special trip just to pay the premium.
- They need to have sufficiently sophisticated **financial systems**² to account for premiums. While some retailers, especially chains such as supermarkets and petrol stations, may have adequate systems, informal retailers may struggle to account effectively.
- As microinsurance is a low-premium, high-volume business, a single retailer needs to be able to access a **sufficient number of potential clients**. Volume is needed to achieve economies of scale that can justify the start-up and administrative costs for the insurer. Consequently, it is advantageous for insurers to collaborate with a network of retailers rather than having to deal with individual stores. This tends to preclude the use of small informal stores unless the insurance is paid for in advance by the retailer, by being bundled with either the product sold or some other form of pre-paid insurance (as described in Section 2 below).
- In all insurance products, there needs to be **trust** in the benefits actually being paid. This is particularly important for microinsurance, as poor policyholders are unlikely to challenge the insurer through the courts and may not be sufficiently financially literate to understand the terms of the policy. Owing to the low insurance usage in many developing countries, low-income people are often unaware of the names of insurers. For example, in South Africa in 2005, a survey of brands conducted by a market research company found very limited recognition of insurance brands (fewer than 1 in 10 low-income consumers could name an insurance company), but extraordinarily high brand recognition of clothing and furniture retailers. A similar scenario exists in India where, as described in Chapter 3.2, clients of Tata-

² In South Africa many retailers have a long history of providing credit to low-income consumers, thus building up the financial services competence of their staff. This is not a necessary condition for retailers to distribute microinsurance, but has undoubtedly helped.

AIG were on the whole aware of the Tata group and trusted it, but had not heard of one of the world's largest insurers.

- Insurers need to have **mechanisms to monitor the performance** of the retailer, and be able to legally compel it to hand over premiums without defrauding them. While it is possible to introduce controls as a deterrent against such fraud, they can be costly, especially in relation to the premium amount.
- It goes without saying that the **retailer must have incentives** to carry out its role, but it is not always as simple as just paying a commission. When retailers sell goods together with insurance on those goods, there is a clear convergence of the retailer's and insurer's interests. In some cases, however, there may be a conflict of interest. Very poor clients paying an insurance premium may purchase less of whatever the retailer is selling.
- Finally, as mentioned in Chapter 3.4, in microinsurance it is particularly important to **provide benefits quickly** in a way that is accessible to the policyholder. This may require empowering the retailers to settle claims before being reimbursed by the insurer. However, not all retailers will be in a position to do this.

2 Microinsurance distribution/product combinations for retailers

There are four primary ways in which microinsurance can be sold through retailers:

1. Bundled insurance linked to the product sold
2. Bundled insurance unrelated to the product sold
3. Voluntary insurance linked to the product sold
4. Voluntary insurance unrelated to the product sold

The most common is to bundle insurance with another product. When the product is purchased, the insurance is automatically purchased. With some bundles, there is a direct link between the product and the insurance; however, with other bundles, this is not the case. The same applies to voluntary insurance products.

2.1 Bundled insurance linked to the product sold

An example of bundled insurance that is linked to the product sold by the retailer comes from a South African furniture group (Ellerine Holdings)³

³ Ellerine Holdings is one of the largest credit retailers of furniture in South Africa. While the Ellerines policy is used for the purposes of illustration, the general findings are applicable to all furniture retailers retailing insurance. For more details on other credit retailers see Chamberlain et al., 2006.

with 1,220 stores across the country. The stores are mostly targeted at lower-income consumers and sell household goods (mostly furniture and electronic items). Insurance policies are bundled when goods are sold on hire purchase (a rent-to-own leasing agreement). A typical Ellerines policy contains four main types of cover:

- **Asset insurance** provides for replacement or repair of a purchased item if it is damaged, lost or stolen. At the discretion of the insurer, the policyholder can also receive cash compensation.
- **Loan insurance** provides for the full repayment of the outstanding balance of the loan to the retailer if the policyholder dies, is injured and/or becomes unemployed.
- **Life insurance** provides a fixed funeral benefit of US\$472 (R3,000) in the event of the death of the policyholder (i.e. does not cover family of policyholder). Any outstanding debt is deducted from the funeral benefit and the remainder is paid to the beneficiaries. An additional benefit of US\$1,575 (R10,000) is paid in the case of accidental death. The full amount is paid to the beneficiaries and no deductions are made to cover outstanding debt.
- **Health insurance** provides antiretroviral treatment (for the period of the credit agreement) if the policyholder is accidentally exposed to the HIV/AIDS virus.

In South Africa, as in many countries, the purchaser/lessee is not compelled to take the retailer's insurance. In practice though, few borrowers are aware of this right.

Claims are lodged with the insurer and the payment, except for life and health insurance, is made to the relevant store. All policy administration and claims management are handled by the relevant insurance company (in the case of Ellerine Holdings, the insurer is a member of the retailer group).

The four types of coverage contained in the policy overlap in a variety of ways, limiting the liability of the insurer and, by extension, the policyholder's ultimate cover. Overlap, for example, occurs if a policyholder's death is non-accidental. In this scenario, the outstanding balance on the policyholder's account will be covered by the life insurance if the outstanding loan balance is less than the sum insured. If the outstanding debt, however, is greater than the defined funeral benefit, the excess of the debt over the defined funeral benefit will be covered by the loan insurance. For the coverage to be in force, the policyholder must not have fallen behind with monthly instalments.

The retailer's management indicated that 95 per cent of all customers purchasing products on hire also buy *its* insurance product.⁴ In the 2004/05 financial year, only 6,400 claims emanated from its 500,000 credit-consumer base. Thus, for every 100 individuals that actually bought the policy at the retailer's stores, only 1.28 claims were filed. This claims ratio could be interpreted as indicating that customers do not experience the contingencies covered by the policy. However, in the South African context of employment instability, high crime rates and high mortality due to HIV/AIDS, this is unlikely. The low claims ratio more probably indicates that few customers actually know that they purchased insurance and therefore do not file claims.

Selling *de facto* compulsory bundled policies has the very obvious advantage for retailers that they do not need to do any selling to the policyholder. The "tick-of-the-box" nature of the transaction means in many instances that they do not have to comply with agent's licensing regulations as they do not provide advice. Compulsory insurance reduces adverse selection (the tendency of the worst risks to apply for insurance). In theory, all of these benefits could be passed onto the client in the form of lower premiums. In practice, however, selling bundled products often results in abuse. In South Africa, 34 to 38 per cent of low-income clients at retail stores regularly pay for purchased items in monthly instalments and have bundled insurance. However, less than 8 per cent of those individuals are aware that they have insurance.⁵

In theory, regulators could improve the situation by compelling stores to (i) specifically inform customers that they have insurance and (ii) advise them that they can purchase the required coverage elsewhere. In practice, this may be difficult to enforce. Even if customers were aware of their options it might make little difference to their behaviour, for a number of reasons. Firstly, the most significant cost of the purchase is the item itself (plus interest costs). Secondly conducting transactions in rural areas can be expensive and difficult for clients; they may not think it worthwhile to shop around for alternative insurance. Or given the dearth of alternative low-income insurance providers in such areas, there may also simply be no other option.

Bundled insurance linked to the product sold could in theory provide relatively cheap cover for some of the most important and costly assets that low-income clients purchase. In practice though, selling products in this manner is often abused; clients are either unaware that they have purchased insurance or have been sold very expensive insurance.

⁴ In other words, 5 per cent of credit customers obtain credit life insurance from a different source.

⁵ Data sourced from the FinScope 2004 survey.

2.2 Bundled insurance unrelated to the product sold

There are few instances of bundled microinsurance where the insurance product bears no relationship to the good or service sold. In India, the Sankat Haran Policy sold by Iffco-Tokio provides accidental death and disability cover. The cover is obtained when clients buy a 50-kg fertilizer bag of Iffco and Indian Potash brands. The receipt for the fertilizer bag acts as proof of payment and the policy document is printed on the fertilizer bag. The amount of cover is US\$90 in the event of an accidental death and US\$45 for certain categories of dismemberment and disability. The insured is the purchaser of the fertilizer bag and a single person can hold multiple policies up to a maximum of US\$2,260 in cover. Claiming on the policy appears somewhat arduous as claimants must submit a variety of documents to Iffco-Tokio directly. This scheme, however, may well be the largest commercial microinsurance scheme in the world. By the end of 2005, the Indian newspaper *The Hindu* (Revathy, 2006), reported that it covered 25 million persons.

Essentially the scheme sells pre-paid insurance, in the sense that the retailer buys the fertilizer, including its insurance component, from a wholesaler. The *retailer pre-pays the insurance premium*, so there is no need for the insurer to collect premiums from the client or, indeed, from the retailer.

On the face of it, in a competitive market for fertilizer and accidental death and dismemberment (AD&D) insurance, it is hard to imagine what value is offered to the consumer by this type of embedding. Any consumer who wanted either fertilizer or AD&D insurance could buy it separately in the required quantities without needing to buy the two together. However, the rural Indian market is not competitive and this may be the only means of distributing such insurance. It is also possible that the addition of AD&D insurance provides an incentive to purchase a particular brand of fertilizer (in much the same way some Visa cards come with similar coverage linked to travel). Another explanation for the existence of this scheme is the regulatory requirements in India, which stipulate that insurance companies must sell a percentage of their policies to socially disadvantaged clients and derive a percentage of total premiums from clients in rural areas.

The insurance is compulsory, which in theory should control adverse selection. With this particular configuration, however, this is not necessarily the case. A person with an extremely risky profession can buy a bag of fertilizer, keep the receipt and the policy document, repackage the fertilizer and sell it on to another farmer; although given the number of people buying insurance, adverse selection is not likely to become a problem.

This model is only appropriate for microinsurance products with single premium payments. In addition, it is unlikely that products offering anything other than minimal coverage could be sold in this fashion. If they were, it would increase the cost of the good or service to a point where a customer who did not want insurance might be disinclined to purchase that good or service.

2.3 Voluntary insurance linked to the product sold

In many developed countries, when a durable good is sold it is quite common for the seller to offer insurance, usually in the form of an extended warranty on the item. A South African retailer, Makro, which sells consumer durables, also provides voluntary extended warranties. The premiums for some of these warranties are sufficiently low to appeal to the low-income market. For example, a two-year warranty extension costs R299 (US\$47) for refrigerators priced below R6,000 (US\$943). This kind of warranty could be beneficial for microenterprises. Many consumer durables purchased from retailers are used in informal household enterprises. Refrigerators in South Africa, for example, are commonly used to run informal catering businesses or to retail meat bought from wholesalers. It may be quite difficult for low-income consumers to purchase independently offered extended warranties, and so the option of being able to purchase it with the product might be appreciated.

2.4 Voluntary insurance unrelated to the product sold

The South African supermarket chain Shoprite targets low-income consumers. Inside each supermarket, there is a “Money Market Counter” where customers can carry out a variety of financial transactions. The counters are intended to increase shopping convenience, facilitate customer loyalty, and provide a range of transaction services, including payment for television licences and of utility bills, with approximately 220 third parties represented at the counters. During the 2004/05 financial year, the number of transactions conducted at “Money Market Counters” reached around 21 million per month.

The supermarket sells funeral insurance at the counters on behalf of the insurer HTG Life. HTG Life is a member of the HT Group, which also includes a funeral service business (Doves and Saffas funeral parlours). The policy covers specified nuclear families (policyholder, spouse and children). The eligibility criteria and cover are given in Table 46.

Table 46

HTG funeral insurance product⁶

<i>Feature</i>	<i>Description</i>
Monthly premium	Determined by age of oldest life covered. 14–55: US\$3.93 (R25); Ages 56–68: US\$6.61 (R42)
Eligibility	Policyholder must be between the ages of 14 and 68. No medical examination required.
Benefit	Ages 0–6: US\$197 (R1,250); ages 7–13: US\$393 (R2,500); ages 14 and older: US\$787 (R5,000); policyholder: US\$787 (R5,000); spouse of policyholder: US\$787 (R5,000).

Source: Chamberlain et al., 2006.

Shoprite is responsible for marketing, selling and collecting premiums on the policy, while HTG Life handles policy administration, claims management and payout. Shoprite earns commission on each policy sold. Since the target group does not have bank accounts with standing order or direct debit facilities, premiums are paid in cash at the “Money Market Counters”.

In the event of a claim, payment may be made in two ways. Beneficiaries have the option of using any of the HT Group funeral providers or other identified agents for the funeral. If this option is selected, the beneficiary qualifies for a discount on the funeral services provided. The second option is to apply for a cash claim, which is payable from the HTG Life head office within 48 hours of presentation of the required documentation. If the customer requires a cash payout, the money is paid into the bank account of the policyholder and/or beneficiaries. If the policyholder or beneficiaries do not have a bank account, the money is paid out at a participating funeral parlour. However, as the latter method poses a security risk, HTG Life tries to avoid it where possible. This raises questions as to the usefulness of the policy for lower-income clients who are still largely “unbanked”. The competitive advantage Shoprite and HTG Life have in being able to collect insurance premiums from clients without a bank account may result in slower policy payouts.

The advantage of selling (and collecting premiums) through the retailer’s extensive distribution network are undermined by the fact that claims payments can only be made at participating funeral parlours. Despite its attractive distribution and cost features, this model has not reached significant volumes of policyholders. In the three years of its existence, fewer than 6,000 policies have been sold. One of the key problems raised is that it is a “pas-

⁶ Information as at December 2005.

sive” distribution model relying on customers approaching the counter and asking for the product. This differs from traditional broker/agent models where products are actively sold. There is also little incentive for the in-store Shoprite employees to sell the product.

South Africa provides another interesting example of using retailers to sell voluntary insurance. The clothing stores Jet and Edgars (both part of the Edcon group) provide insurance to low-income clients (though Edgars sells predominately to higher-income clients) for those who qualify for the store’s credit card. There are more than 280 Jet stores located across South Africa, while Edgars owns more than 150 South African stores (*see Box 83*).

Edcon and Hollard Insurance Ltd established a joint venture, Edcon Insurance Services, in June 2001. The two companies agreed that the Edcon group would sell a wide range of insurance policies underwritten by the Hollard’s life and non-life insurance companies. The insurance policies have store branding (i.e. not that of the insurer) to exploit high retailer brand awareness.

Both Edcon and Hollard Insurance were actively involved in the design of the products. All the products were designed to suit the needs of the average Edcon customer. Policies are sold over the counter. The sales personnel provide the insurance as a “tick box” offering and therefore do not need to fulfil the regulations that govern agents. Edcon Insurance Services is responsible for the marketing and sales of the policies, while the retailers collect the premiums and pass them on to Hollard. The insurance company manages the policy and claims administration and handles the actual payment of claims.

The rationale behind the store-card model, as used here, is that monthly premiums can be more easily collected if they are simply added to the store account balance. In other words, the monthly premium is paid together with the total monthly instalment due (which can be paid in cash). A drawback of this approach is that customers who do not qualify for the cards cannot purchase insurance. The model therefore excludes individuals who could potentially afford a small monthly insurance premium, but do not qualify for credit.

The scheme has proved highly profitable. During the 2004/05 financial year, a growth of 23.4 per cent in active insurance policies was experienced, increasing Edcon’s profit for insurance-related products from US\$30.2 million to US\$41.4 million.

Box 83

Retailers and rural areas

The stores described all have branches in rural areas, which may be more common in South Africa than other countries. Various pieces of South African legislation from 1923 divided South Africa into “prescribed” (mostly urban) and “non-prescribed” (mostly rural) areas, and strictly controlled the movement of black South Africans between the two. Apartheid authorities

actively discouraged permanent black settlement in large urban centres. The existence of these laws and other restrictive apartheid laws helped to create “urban slums in rural towns”. The population density of these areas created opportunities to establish retailers that might not exist in other rural areas of developing countries with more dispersed rural populations. Consequently, this delivery model for microinsurance might be more effective in reaching rural South Africans than the rural populations in other countries.

One advantage of selling voluntary products through a retailer, or other organization with many low-income customers or members, is that the distribution channel can use its significant client base to get discounts from insurers. This is in addition to any savings that they are able to pass on to consumers as a result of lower distribution costs. Indeed, in some developed countries, for example the United Kingdom, the cheapest life insurance policies are often sold by supermarkets.

Although not retailers, some trade unions have experience selling voluntary insurance. In the United States, the largest trade union federation, the AFL-CIO, has negotiated a set of discounts on a variety of consumer and financial products for its members (*see Box 84*). It is mentioned here because many retailers have membership clubs or loyalty schemes that can be tapped in a similar way to that in which the AFL-CIO has made use of its membership to sell insurance.

Box 84

AFL/CIO’s Union Privilege Scheme

From 1986, “Union Privilege” has used the AFL/CIO’s vast membership to negotiate discounts on a range of products and services, including a variety of insurance products. The scheme promises to ensure the quality of insurance provision through careful selection of partner insurance companies and regular monitoring. It has also used its bargaining power to get additional riders to make the policies more attractive to members. For example, for one life insurance product, workers on union-sanctioned strikes, lockouts or involuntary lay-offs that last for more than 30 consecutive days do not have to pay premiums for 3 months during the industrial action. For the AD&D product, policyholders do not need to pay accident insurance premiums for the period of a union-sanctioned strike or lockout, up to a maximum of one year. This gives value to the members it serves (they buy insurance at a cheaper price), it strengthens the unions by providing an additional reason for members to join, and it provides a new stream of income to participating unions – commission income.

Source: Adapted from Koven, 2006.

Another advantage for policyholders is that the distributor bears significant reputation risk. The distribution channel is the face of the policy. If policyholders are dissatisfied with the policy, they may terminate their relationship with the retailer or trade union.

One concern with voluntary insurance products sold by non-specialized distributors is that the consumer is often buying an important product with life-changing consequences. Policies sold by retail stores are often sold through a “tick of the box”. The terms and conditions may be presented to the customer by a store attendant, or simply left hidden in a stack of other information. This approach may be inexpensive, but it may also be of poor value. In theory, the terms and conditions are on the policy document, but for microinsurance this is not an appropriate means of educating the customer, nor does this transaction method facilitate questioning by a potential client about the terms of policy.

3 Conclusions

It is premature to draw firm conclusions from the few examples of retailers as distributors of microinsurance. What follows are some initial thoughts, many of which will need to be tested through further research.

Leaders and followers

The driving force behind the development of retailer microinsurance distribution in these examples seems to be the initiative either from the retailers looking to expand their value offerings and increase client loyalty (as in the Shoprite case), and/or from insurers needing to fulfil regulatory requirements (as in the Indian and South African cases). In these few examples, retailers or regulators are leaders, and insurers are followers.

The advantages of retailers as microinsurance distribution agents

- The trust in the retailer brand is one of the critical attractions of this distribution channel. It reduces the sales effort and, hence, the cost of delivery. However, retailers also need to consider the brand risk they would face if insurance did not meet clients’ expectations.
- A key advantage of this distribution mechanism is that it allows for cash premium collection and claims payment at places that are more conveniently located than the offices of the insurance company and its agents. In developing countries, this will ensure that the model does not simply cannibalize the existing insurance market (as may be the case with retailer distribution in the developed countries with saturated insurance markets), but actually expand the market to individuals who would not otherwise have access to insurance.

However, not all retailers have fully exploited this opportunity (e.g. Shoprite's claims-payment procedure).

- An obvious advantage of retailer distribution is that it provides centralized access to the retailer's client base, which would otherwise be very difficult for insurers to reach. In a number of cases, the retailer controls access to the client base, which means that the insurer cannot access it without continuing the relationship with the retailer (e.g. for retail account holders). This places retailers in a powerful negotiating position with insurers.

Key problem of voluntary insurance sold through retailers

It is clear that retailers can reduce the costs of insurance distribution to the low-income market. There are even a few examples of voluntary insurance sold through retailers. The problem seems to be that retailers are not necessarily good at *selling* insurance. Staff need to be trained and motivated to sell voluntary insurance. This experience mirrors that of many microfinance institutions. As the Shoprite example demonstrates, it is unclear how successful this passive approach can be for a product that is famously "sold not bought".

Bundled products: Problem of abuse

- Although bundled insurance products simplify premium collection and ensure a better risk profile, it is not clear whether consumers necessarily benefit. Lower costs and risks are not always reflected in the premium.
- Given the low literacy rates associated with the target market, the risk of mis-selling products to clients, who may be unaware of their bundled purchase, is significant.
- Even if the relationship is not abused, embedding ultimately reduces the incentive of the insurer to ensure that its product meets the consumer's needs.

Bundled products: Problem of ongoing protection

Insurance bundled with consumer credit products has the same problems as some MFIs' insurance products linked to loans, where the need for insurance coverage extends beyond the loan repayment period.

Bundled products: The limits of bundling insurance with an unrelated product

Embedded insurance products that are unrelated to the primary good or service sold seem to be a means of marketing the primary good or service and tend to be quite basic in their cover and benefits. Any insurance product that offers significant value is likely to cost more and potentially push up the cost of the primary good or service to a point where it is no longer attractive.

“Tick-the-box” insurance: The pros and cons

There is an inherent trade-off between product simplicity and lower costs on the one hand, and advice and education on the other. While retailers can reduce distribution costs by using simple products that are sold through a “tick-the-box” method, it is often low-income clients who need financial advice and education the most. However, these services increase the costs of policies and decrease affordability for clients. As a minimum, appropriate disclosure of product information is required to ensure that clients are aware of the features and conditions of the products they have purchased. This is not only in the business interest of the seller (increasing retention and building long-term clients), but also avoids mis-selling and the concomitant risk of costly regulatory intervention.

So what then is the potential of the retailer distribution model for microinsurance? The preceding discussion reaches conflicting conclusions on the potential and reality of distributing microinsurance through retailers. Retailer distribution presents opportunities to overcome some of the key barriers to microinsurance distribution, which could benefit both providers and clients of insurers.

However, it is clear that this distribution method is still a relatively new and untested phenomenon in the low-income market. In particular, the evidence on the ability to sell voluntary insurance through retailers is less than positive and there are shortcomings in the current models that need to be addressed to ensure success. Critically, retailers need to find ways of replacing the market-making function of traditional insurance intermediaries without undermining their low-cost distribution advantages. Without this, it is unlikely that the voluntary models will achieve any scale in markets that are not familiar with the benefits of insurance.

Bundled insurance on the other hand has achieved much success for the retailers and insurers. In the examples reviewed, however, little benefit has been passed to the clients who are probably paying too much and are often unaware of their cover. If disclosure is improved, this model can provide valuable protection to clients who would otherwise not have access to such insurance. Critically, a shift has to be made to providing value to the client rather than using insurance simply to extract larger profits. This new opportunity comes with great potential for consumer abuse and will require active monitoring and regulation by consumer groups and authorities.

Microinsurance: Opportunities and pitfalls for microfinance institutions

Craig Churchill and James Roth¹

The authors appreciate the substantive comments and suggestions provided by Javier Fernandez Cueto (Compartamos), Lemmy Manje (ILO), Michael McCord (MicroInsurance Centre) and Constantin Tsereteli (Constanta Foundation).

As discussed in Chapter 4.2 and elsewhere, microfinance institutions represent an important distribution channel for extending insurance to the poor. However, it is also important to turn the lens around and look at this issue from the MFI's perspective.

To begin with, should an MFI get involved in offering insurance? When microfinance institutions are interested in insurance, their primary motivation is often to reduce their credit risk in the event that borrowers or their family members experience death, illness or other losses. If insurance can help protect the households in such circumstances, it will indirectly safeguard the MFI's portfolio.

Another significant motivation behind the interest in insurance is to improve the welfare of their clients. MFIs typically have dual missions to alleviate poverty or promote economic development while generating a profit (or covering their costs). The social mission of improving the welfare of poor households can be enhanced through the protection provided by insurance.

There are also a number of legitimately commercial reasons why MFIs might be interested in providing insurance, such as:

- **Enhancing retention:** Many MFIs realize that they need to offer a variety of products to enhance retention, so that even when clients do not want a loan, they may still appreciate a savings account, a wire transfer service or...insurance protection.
- **Product profitability:** A diverse product menu provides cross-selling opportunities and spreads the acquisition costs for a client across multiple products, enhancing product profitability.

¹ The examples from Compartamos (Mexico) and Constanta (Georgia) were provided by the readers and were not drawn from the case studies.

- **Diversifying income streams:** Microinsurance creates an additional source of income either from profit if the scheme is provided in-house (and well-managed), or from fees if done in partnership with an insurer. The latter situation is of particular interest to MFIs, which welcome opportunities to earn income without taking risks.
- **Reach out to new markets:** In heterogeneous low-income communities, there may be persons who are not interested in credit or savings, but are keen on insurance, although in reality, few MFIs have taken advantage of this benefit, since it would require having a delivery channel exclusively for insurance, which most MFIs have thus far avoided.

Of course, there are also disadvantages to offering insurance. It is a different business from savings or credit, requiring different expertise. Even offering insurance products in partnership with an insurer can be time-consuming and demanding. A number of organizations, like ProCredit Banks in Eastern Europe, have no interest in offering insurance, directly or indirectly, so they are not distracted from their core services. Furthermore, low-income households have finite resources. If an MFI offers insurance, some clients might have to choose between repaying a loan or making a deposit and paying an insurance premium.

If an MFI believes that there are more pros than cons, and decides that it wants to branch out into the brave new world of insurance, there are two key questions it needs to consider when offering microinsurance:

1. Through what institutional arrangement should it offer insurance?
2. What types of cover should it offer?

I Institutional arrangements

If an MFI wants to offer insurance to its clients, there are four main ways to do so: a) in partnership with an insurance company, b) by creating its own insurance brokerage, c) by self-insuring or d) by creating its own insurance company.

I.1 Partner-agent model

Under what circumstances is one option preferable to the others? Chapter 4.2 describes in detail the advantages and disadvantages of collaborating with an insurance company, and strategies for improving the partnership. Certainly, if no partner is available or willing to offer insurance through the MFI, then it could go on its own. However, the possibility of not being able to find

an interested insurance partner is becoming increasingly less likely as more insurers seek opportunities to reach new markets. MFIs are also becoming more convincing, arming themselves with arguments and experiences to persuade insurers that this is indeed a valuable market opportunity for them.

In general, if an MFI cannot entice an insurer into a partnership, it is probably not effectively communicating what it has to offer. Many insurers are attracted to the prospect of accessing many new clients through a cheap distribution network.² MFIs should recognize that insurers and bankers may have very different attitudes toward the masses of low-income people. For bankers, whose money is at risk when they lend, the poor are a risky market. Insurers, however, tend to be interested in ways of reaching an expansive market cost-effectively. Volumes speak volumes.

To make the partner-agent work effectively for MFIs, the following recommendations emerge from the experiences of MFIs around the world:

- **Tell them what you want:** To get good products and processes from insurers at a decent price, MFIs need to know what they want and they have to sit in the driver's seat in the negotiations. The larger they are, the more demanding they can be. Several MFIs, including Compartamos (Mexico) and some Opportunity International affiliates, have designed their own product specifications and then sent requests to insurers to bid on their proposed product.
- **Know your stuff:** MFIs need to speak with authority, using language that insurers understand backed up with compelling data. One advantage of an MFI is that it can often create useful actuarial data from its own experience of working with clients, to which the insurer otherwise would not have access. For example, before it began negotiating with insurers, FINCA Uganda researched and documented its historical mortality experience.
- **Do not be afraid to switch partners:** MFIs do not have to be wedded to one insurance partner forever. If the insurer is not performing, the MFI can look for a new partner, although this should not be taken to extremes – ASA, an Indian MFI, changed insurance partners too frequently, which caused some confusion among clients and staff.
- **Choose a trustworthy insurer:** It is often preferable to work with a well-known insurance company because it helps create trust and confidence in insurance. Without trust, clients will be unwilling to pay premiums today against the promise of a possible future benefit.
- **Involve the insurer:** The alternative to changing partners is to get existing partners to improve. Shepherd (India) found that it was useful to invite insurers into the field to enable them to understand the target market better

² For advice on negotiating with insurance companies, see Churchill et al., 2003.

and to begin to recognize the difference between insurance and microinsurance. This can be reinforced through an annual review meeting with the insurer.

- **Ask for training:** A major challenge in introducing insurance is training the MFI's employees, particularly the frontline staff who are responsible for sales and service. Several MFIs have persuaded their insurance partners to train their employees in insurance in general and in the products in particular.
- **Manage claims:** An efficient claims-processing system is one of the most important points for negotiation. As described in Chapter 4.5, when the benefit amounts are small, MFIs should insist that they pay the claims (at least for life insurance), and then be reimbursed by the insurer, on the basis of documentation appropriate for their clients.
- **Create a review committee:** Since claims processing tends to be one of the most contentious issues, Shepherd formed a review committee, with representatives from the MFI, insurer and clients, which meets quarterly (or more often if necessary) to improve claims processes.
- **Eliminate exclusions:** Strive to persuade insurers to drop as many exclusions as possible, even if the MFI has to pay a higher price, because that simplifies the product and makes it easier to explain to customers. It also reduces claims rejections that could cause significant public relations problems for the MFI.
- **Maintain and analyse data:** MFIs should maintain good information about insurance performance, enabling them to develop expertise over time and to push insurance partners for better deals. An appropriate and “actuarially-approved” MIS is crucial (*see Chapter 3.5*).
- **Determine the costs:** MFIs need to conduct a costing analysis to determine how much they need to earn in commission (or through a premium mark-up) to cover their administrative expenses.
- **Own the clients:** Some entrepreneurial insurance companies might be interested in stealing the clients in the future. The MFI should always “own” the client. This can be done if the MFI is always the institution that sees the client.
- **Share the profits:** Instead of receiving a commission, the Zambian MFI Pulse has negotiated a profit-sharing arrangement with Madison Insurance (*see Chapter 3.6*), which corresponds more with the spirit of microinsurance, if the MFI is willing to take a bit of the risk.

1.2 Insurance brokerage or agency

The creation of an MFI-owned insurance brokerage is essentially a more sophisticated version of the partner-agent model. This approach, often used by credit union networks (*see Chapter 4.1*), facilitates access to formal insur-

ance for MFIs and members alike. As with the partner-agent model, this arrangement has the advantage of outsourcing the risk to formal insurers.

The advantage of the brokerage arrangement over the basic partner-agent model is that an organization affiliated to an MFI (or a group of MFIs) develops insurance expertise to negotiate the best deals on behalf of the MFIs and their members. The brokerage is not tied to any one insurance company, so it can explore various options on behalf of its two main customers, the MFIs and their clients. In addition, the brokerage is not limited to using MFIs as the distribution channels. Once it understands the needs of the low-income market, it can explore other strategies for extending insurance to poor households and businesses. As mentioned in Chapter 4.5, Opportunity International has recently launched such an initiative (the Micro Insurance Agency). The insurance brokerage could also be seen as a first step towards creating an insurance company (described in more detail below), although that does not necessarily have to be the objective.

1.3 Going solo

A third option is for MFIs to self-insure, in other words, to carry the risk themselves. There are compelling reasons why some microfinance institutions would want to self-insure, as well as some equally strong arguments against it.

Some MFIs do not want to work in partnership with an insurer for ideological reasons. Microfinance institutions with strong social missions may not believe that profit-making firms should provide financial services to the poor. MFIs with such ideological commitments will not be swayed by arguments that profit-making insurance companies could possibly provide cheaper and better insurance to their clients.³

Among the non-ideological reasons for self-insurance is a belief that the MFIs (or their customers) will have to pay extra for the insurer's overhead. For the most basic products, like credit life, that logic might be valid. However, basic credit-life insurance largely benefits the lender since it means the MFI does not have to solicit loan repayments from the deceased's survivors.⁴

³ In some cases, ideological preferences can play an important role in partner selection. For example, Shepherd selected public insurance partners because it deemed it a national duty to work with the state insurer.

⁴ There is some debate about the usefulness of credit life insurance. Some MFIs feel that it is an unnecessarily complicated means of dealing with loan losses due to death, and they prefer to just write off the loan and provision accordingly. Such an argument might be valid for predictable loan losses due to death, but would not be appropriate if an MFI experiences a natural disaster or other covariant risks. The provisioning approach is also not relevant for small MFIs that cannot afford to write off loans or for MFIs granting larger loans, creating a concentration risk, or if the mortality rates are volatile or changing, as in an area with high incidence of HIV/AIDS.

If the MFI really wants to reduce the vulnerability of its customers, more complicated products are required – products that an MFI probably cannot offer on its own.

Both TYM (Viet Nam) and CARD (Philippines) had negative experiences trying to enhance customer value on their own. They provided credit life on a self-insurance basis and generated significant surpluses. Consequently, they thought it would be a good idea to offer additional benefits, by including other family members or by covering additional risks. They added these benefits, however, without assessing the impact that they might have on claims. As a result, CARD's pension plan nearly bankrupted the company, and TYM's hospitalization benefit threatens to do the same even though the benefit is extremely modest.

Another concern surrounding self-insurance is the extent to which an MFI will cope if it experiences catastrophic losses. This problem cannot be emphasized enough. The primary reason why MFIs should not self-insure – besides not having the expertise to price and design products appropriately – is because they will have difficulty meeting claims if many clients are affected by a peril at the same time. Since they are not formal insurers, they do not have access to reinsurance, which is how insurers cope with covariant risks. Reinsurers essentially create a larger risk pool than an insurer can achieve on its own, by spreading risks across national boundaries, but only licensed insurers can access reinsurance (*see Chapter 5.4*).

VimoSEWA (India) learned this lesson the hard way. After several years of negative experiences with insurance partners, it began offering in-house health insurance in 1996, and then added asset insurance in 1998. Initially, VimoSEWA's transition to self-insurance had positive financial and service benefits – claims were paid faster and not rejected, and VimoSEWA began building up some reserves. However, when the January 2001 earthquake struck Gujarat, over Rs. 3.4 million (US\$75,000) was required to satisfy claims, causing a severe financial strain. Prior to the earthquake, annual payouts for asset protection were below Rs. 30,000 (US\$662). This experience helped VimoSEWA appreciate the need for reinsurance, and led the organization back to the partner-agent approach.

While natural disasters like floods and earthquakes are usually used as examples to scare MFIs away from self-insurance, it was something more mundane – a truck accident in which several borrowers died – that convinced ASA to find an insurance partner. If MFIs start offering larger loans, they may find that the death of just a few borrowers can seriously drain a self-insurance fund. Smaller MFIs are also more vulnerable if they self-insure because they have a small risk pool (although they are also in a weaker position to strike up an appropriate partnership with an insurer).

The main point is that a self-insuring MFI must think carefully about how it will control covariant risks. It could exclude such risks to limit its exposure, which is what Spandana does, although such an approach leads to clients being abandoned when they need help most. Moreover, excluding cover does not help the MFI manage its credit risk in a disaster situation. Alternatively, a self-insuring MFI could solve this problem by buying catastrophe cover with an insurance company, so the MFI covers idiosyncratic risks in-house while outsourcing covariant risks to an insurer.

A further argument against going solo is that in many countries it is illegal to offer insurance without a licence. Regulators generally do not bother with small microinsurance schemes. Some organizations manage to disguise their schemes by calling the service a member benefit instead of insurance. Insurance regulators may be willing to look the other way, or may not even realize that the scheme exists. However, once it achieves significant scale, it is bound to attract attention. In addition, regulated MFIs are probably not allowed to keep insurance liabilities on their balance sheets, so for them (or MFIs planning to transform), self-insurance may not be an option. Donors are also becoming increasingly wary of supporting organizations that are circumventing insurance regulations.

Some MFIs, like TYM, choose self-insurance because they want to retain the funds as a source of loan capital. The situation in Viet Nam is unique because the regulatory environment has prevented MFIs from accessing wholesale finance, except from donors who have become somewhat parsimonious. Consequently, TYM (and other Vietnamese MFIs) have had to be creative to satisfy their funding requirements. TYM's insurance fund has been a source of loan capital, despite the fact that it is unwise to combine insurance and credit risks.

Another reason why MFIs might want to self-insure is that they do not want to share the insurance profits with another organization. Similarly, if going solo means lower overhead costs, the coverage could be cheaper for the clients. Consequently, some MFIs contend that they can provide greater customer value without involving an insurer. As shown in Table 47, using the claims ratio (the percentage of premiums returned to policyholders in the form of claims) as an indicator of customer value, the evidence suggests that self-insurance provides greater value, albeit from a very small sample of experiences.

Table 47

Does self-insurance provide greater client value?

<i>Self-insurance</i>		<i>Partner-agent</i>	
<i>MFI</i>	<i>Claims ratio</i>	<i>Insurer</i>	<i>Claims ratio</i>
TYM	53	AIG Uganda	37
Spandana	85	Madison	10

In-house schemes should be more efficient. A lot of money is saved on administration and marketing because the product tends to be simple and generally there is one product for all. In addition, in-house schemes do not comply with technical rigour or insurance regulation, both of which are expensive. They also do not have to pay for the additional overhead and profit margin of an insurance company.

Besides costs, another aspect of customer value is the service standard for claims payments. For MFIs that have tried working with insurers and given up, problems with claims –including delays and rejections – are probably the number one reason for the divorce. If the MFI self-insures, it can pay claims quickly and impose less onerous documentation requirements on the beneficiaries. For example, when Spandana was collaborating with LIC, claims often took two to three months or more to be paid. The MFI moved the scheme in-house, and now 73 per cent of claims are settled within seven days.

Experts have mixed opinions on the topic of self-insurance. Leftley (2005) feels strongly that there are no good reasons why MFIs should take on insurance risk as long as there is existing underwriting capacity in the country. Other experts are more open-minded about the issue, willing to concede that self-insurance might even be preferable to the partner-agent approach if certain conditions are met: 1) the MFI is large enough to pool risks (at least 10,000 members) and those risks are reasonably homogeneous, 2) the product is kept simple, 3) the MFI obtains catastrophe coverage from an insurance company, 4) the MFI makes use of appropriate technical assistance to help with product design, pricing, data management and performance monitoring and 5) regulators will allow it.

Finally, there are cases where an MFI chooses to go solo, despite an active insurance market, because it cannot entice insurance companies to provide the coverage sought by clients at an affordable price. Going solo under such conditions needs to be done with extreme caution. If the market is unwilling to provide a service for a particular price, there is often a good reason: it may not be viable.

1.4 Creating an insurance company

The fourth option is for an MFI or an association of MFIs to create their own insurance company. For many years, in many countries, credit unions and cooperatives have satisfied their insurance needs through insurers owned by the association and its members. As discussed in Chapter 4.1, the typical approach has been for the credit unions to create a brokerage company that facilitates access to insurance for the CUs and members alike. Over time, the brokerage builds up sufficient expertise in underwriting, settling claims and managing data, and amasses sufficient funds to form a credit-union-owned insurance company.

In some jurisdictions, it might be appropriate for other types of MFIs or MFI associations to create their own insurance company. Indeed, CARD has done just that, creating a mutual benefit association that is “owned” by the members, but structured to meet the insurance needs of the MFI. Some advantages of creating an insurance company over self-insurance are that it:

- separates the credit and insurance risks into different organizations,
- ensures that expertise is engaged in the management of the insurance business,
- can collaborate with multiple distribution channels to extend insurance to the poor and hence reach many more people,
- gives the microinsurer access to reinsurance.

Compared to the partner-agent approach, an MFI-owned insurance company allows the MFI greater influence on product design and service standards. Furthermore, it enables any profits to be redistributed to the policyholders. However, the management of the insurance company should be kept at arm’s length from the MFI so as not to jeopardize the soundness of its insurance decisions. In particular, careful consideration should be given to the investment strategy, since it is unwise to mix the credit and insurance risks by investing too great a proportion of premiums in the MFI’s loan portfolio (*see Chapter 3.6*).

The transformation of an informal insurance scheme into an insurance company is not without its challenges. In some jurisdictions, there may be significant start-up and reporting requirements that do not justify the effort. For years, SEWA has had its sights set on creating an insurance company. However, it has not been able to raise the minimum required capital and the Indian insurance regulators are not interested in making an exception for microinsurance.

2 The type of insurance

One of the key factors in deciding what type of insurance an MFI should offer is its motivation for doing so. In general, an MFI's motivations fall into two categories: 1) organizations that want to offer insurance primarily to reduce their credit risks by being able to recover loans if borrowers die or are too ill to repay and 2) MFIs that are primarily motivated to assist their clients in managing risks and to cope with crises and economic stresses (*see Box 85 for an example of the second category*). Of course, many organizations may be motivated by both objectives, but their primary motivation will probably influence their choice of insurance services and the means of offering them.

Box 85

Reducing the vulnerability of the poor: The case of Shepherd, India

Shepherd is very clear that its motivation for offering insurance is to reduce the vulnerability of the poor. In doing so, it has designed a comprehensive strategy for risk prevention and risk management that incorporates insurance among a range of measures, including:

- **Food security:** Group members are requested to save a fistful of rice at each meeting; as this rice-saving accumulates, group members can either borrow from it or it can be donated to more needy community members.
- **Income security through life insurance:** Shepherd's core business is the provision of savings and credit through self-help groups (SHGs), whereby loans are typically used to support income-generating activities. To protect the household from the death of a breadwinner, group members (and their spouses) can choose between four different life insurance schemes that Shepherd offers on behalf of insurance companies.
- **Income security with livestock:** For SHG members who take out loans for cows and other livestock, Shepherd promotes a three-pronged strategy: prevention, promotion and protection. *Prevention* is addressed through regular cattle-care camps that Shepherd organizes so that a veterinarian can identify and treat poor households' main asset. For *promotion*, Shepherd has trained barefoot veterinarians to educate SHG members to properly care for their animals and to provide ongoing treatment if necessary. For *protection*, Shepherd offers voluntary livestock insurance on behalf of an insurance company covering the natural and accidental death of the animals.
- **Health security:** In 2003, Shepherd introduced UniMicro Health Insurance in partnership with United India Insurance Corporation (UIIC) to cover in-patient treatments (*see Table 18 in Chapter 3.1*). To complement the insurance product, Shepherd organizes regular medical camps to con-

duct check-ups for illness and disease. Shepherd also offers emergency loans that are primarily used for childbirth through its Sugam Fund (*see Box 23 in Chapter 2.4*).

- **Asset security:** A rider on the UIIC UniMicro product includes hut insurance that pays a benefit of US\$100 if the policyholder's house burns down.

Source: Adapted from Roth et al., 2005.

In general, it is easier for MFIs in the first category to meet their objectives than for those in the second category. Owing to its relative simplicity, basic, credit-linked insurance is more likely to be available to the MFI and more affordable to the client, and it is more likely that the MFI could offer it on its own, whereas comprehensive coverage – to protect the poor from the many risks that they really worry about – is very difficult for an MFI to offer on its own and may not be available from other sources.

If MFIs are motivated to offer insurance primarily because they want to help their clients manage risks, and if they are not already offering savings, then that should be their first priority (where the law allows them to accept deposits). As described in Chapter 1.2, the poor are vulnerable to a range of risks and economic stresses, many of which represent relatively small but nagging expenses for which insurance is not an appropriate solution. Insurance covers larger losses and is very risk-specific; for example, a life insurance policy cannot help someone whose valuables are stolen, or health insurance cannot help someone rebuild a destroyed house. Savings (and emergency loans) are more flexible and responsive than insurance in coping with risks. The main difficulty with savings as a mechanism for coping with risk is that the funds are frequently insufficient to cover the loss and their use leaves the saver vulnerable to further risk.

MFIs with a broader development objective should also consider helping their clients to prevent or mitigate their risks, like Shepherd which offers health workshops and cattle-care camps. While an MFI might undertake prevention strategies to fulfil its social mission, such measures could have the additional advantage of reducing claims, having a positive and cost-effective impact on claims experience (*see Chapter 3.9*).

There appears to be a trade-off between reaching many people with a simple product and reaching fewer people with more complex, varied, and voluntary insurance. In general, it makes sense for MFIs to start with a simple life policy to learn about insurance. Simple products work best because they are easier to administer and easier for clients to understand. Once MFIs know how to manage insurance risks (either on their own or in partnership with an insurer), then they can move on and provide coverage that better

meets clients' needs. Similarly, once the market better understands what insurance is, and begins to develop an insurance culture, clients will be more willing to pay for broader benefits.

In selecting insurance products, it is important for MFIs to recognize that they cannot cover all risks and clients cannot afford to buy numerous insurance products. Indeed, this might be a reason to avoid insurance altogether, since the MFI does not want clients to pay insurance premiums at the expense of loan repayments or savings deposits. If the MFI does decide to go ahead with insurance, the challenge is to figure out the most cost-effective solutions to their clients' primary problems.

2.1

Integrated or stand-alone?

To offer insurance cost-effectively to the poor, one of the main strategies is to combine it with another financial service, i.e. with savings or loans, so that the transaction costs can be minimized. Since credit is the core business of most MFIs, the insurance and loan terms can coincide so clients can renew their loan and their insurance at the same time. By linking cover to the loan, the MFI can also make the premium easier to pay by adding it to the loan amount. However, as discussed in Chapter 2.3, not everyone wants a loan, and even people who want loans do not want them all the time, so credit-linked insurance provides incomplete coverage.

Consequently, a link between savings and insurance not only provides more continuous coverage than the credit-insurance link, but it can also significantly reduce the transaction costs. For the life savings product, for example, there are no transaction costs for clients since they do not have to pay a premium (they accept a lower interest rate on their savings instead). For other savings-linked insurance products, premiums can also be paid by automatically deducting the amount from the savings, although there is a public relations risk that depositors may not be aware that the money is being deducted (*see Chapter 3.3*).

From an MFI's perspective, the insurance products that make the most sense are integrated into or linked to the organization's core services of credit and possibly savings. Not only do integrated products enhance efficiency, but also they bolster the MFI's core products. Property insurance, for example, makes the most sense when linked to assets purchased with a loan from the MFI, such as a house, business equipment or livestock.

Still, there may be justification for considering stand-alone insurance. Although the main examples from the case studies of stand-alone insurance offered through MFIs were the credit unions, other types of MFIs might see this as a possible growth area. One of the biggest challenges would be the

staffing structure, since the sale of stand-alone insurance would require greater expertise of field staff (*see Chapter 3.7*).

The strongest argument in favour of offering stand-alone insurance products is to retain policyholders who want to stop borrowing. MFIs that offer loan-linked insurance should seriously consider a continuation policy that enables clients to retain insurance cover between loans. As long as the MFI has a premium-collection method that is independent from a loan, this is a fairly low-risk product because it does not require additional screening.

A second reason to offer stand-alone insurance is to expand the MFI's market, reaching people it cannot serve through savings and loans. If the MFI does adopt that approach and it sells microinsurance to non-members, the organization (or its insurance partners) is vulnerable to adverse selection risks. To control this risk, insurance should only be offered to persons who have joined a group for purposes other than accessing insurance, or increase benefits gradually over time (*see Chapter 3.1*).

2.2 Issues with long- and short-term insurance

Short-term insurance is easier for MFIs to offer than longer-term coverage. It is easier to predict whether an insured event will occur in the next year than over the next five or ten years. If an insurer makes errors in the pricing, it is only committed to those mistakes for a short period of time, after which it can make adjustments. It is strongly recommended that microfinance institutions do not get involved in long-term insurance on their own.

Furthermore, many MFIs are not in a position to offer long-term insurance in partnership with an insurance company, because their delivery systems typically revolve around short-term loans. In India, Tata-AIG (an insurer) and the Bridge Foundation (an MFI) linked up to sell a long-term life insurance product that required premiums to be collected over many years. The pilot proved unsuccessful because the loan term and the insurance term did not coincide. When clients decided to stop borrowing, the MFI did not have a mechanism for them to continue to pay their premiums, resulting in many lapsed policies.

An MFI that uses a savings account as a delivery mechanism could theoretically offer long-term insurance. Yet microfinance institutions may see long-term insurance offered on behalf of an insurance company as competition for the MFI's own savings products.

2.3 Health insurance

Health insurance is a difficult product for MFIs to offer, but there are some examples – including BRAC and Grameen in Bangladesh, SEWA and Shepherd in India, AssEF in Benin, MFIs collaborating with Microcare in Uganda, and TYM in Vietnam – that provide insights and lessons for other MFIs. The link between the MFI's core services and health insurance is not particularly strong, and therefore most MFIs tend to steer clear of such a complex and expensive insurance product.

Yet two compelling arguments may entice MFIs into the choppy waters of health insurance. First, MFIs with a strong social agenda may see themselves as much more than just a microfinance institution, which is certainly the case with the MFIs that provide health insurance in Bangladesh and India.

The second argument is that health expenses, for borrowers and family members, could adversely affect an MFI's loan portfolio. This was a motivation behind FINCA Uganda's initial relationship with Microcare. AssEF had a similar motivation. Its market research determined that, without protection against the financial risk associated with illness, AssEF's members often used their income-generating loans to pay for health expenses, and then had difficulty repaying the loan. Their other options of covering health costs – withdrawing from their savings accounts, borrowing from moneylenders or selling productive equipment – all had negative effects on the microenterprise, and consequently the MFI's loan portfolio. AssEF sought to address the root cause of this problem by providing health insurance.

Based on the experiences of MFIs offering health insurance, there are three possible models:

1. Health provider model

Both BRAC's Micro Health Insurance Programme and Grameen Kalyan are built around their own healthcare clinics, which provide the vast majority of the healthcare services. In BRAC's case, the clinics and the insurance scheme are managed separately; in both cases, the clinics and the health insurance scheme are independent from their parent company's microfinance operations. The only link is that microfinance members get a premium discount, and the microfinance staff members are informally involved in marketing.

2. Partner-agent model

VimoSEWA, Shepherd and Constanta Foundation (Georgia) all provide health insurance on behalf of an insurance company. As a result, the MFIs are primarily responsible for the sales and client education, but (except for

VimoSEWA) are not involved in product design, data management or claims payments, nor are they involved in the provision of healthcare.

3. *Self-insurance*

Both AssEF and TYM provide the insurance on their own, including designing the product and carrying the risk. In TYM's case, it offers a hospitalization benefit of VND 200,000 (US\$13) payable only once a lifetime, so it is both simple and of limited value. AssEF, however, provides very comprehensive coverage, including 70 per cent of many healthcare expenses as long as they are performed by contracted healthcare providers. The MFI's insurance department pays the claims directly to the clinics and hospitals.

MFIs interested in offering health insurance would be wise to keep the scheme at arm's length from their microfinance activities. Unlike life insurance, where it is advantageous for the MFI to manage claims, with health insurance the MFI should steer clear of the administrative burden of claims processing. In addition, as discussed in Chapter 2.1, it is difficult for health microinsurance to be self-sustaining. Consequently, MFIs need to ensure that any insurance losses do not adversely affect their microfinance operations.

Ironically, AssEF has experienced the opposite problem: the microinsurance scheme has been suffering because of the poor performance of the loan portfolio. Since microinsurance was integrated as an additional voluntary service for microfinance members, the insurance initially reaped the benefits of the members' confidence. However, due to increasing competition among microlenders, the MFI experienced high delinquency and drop-out rates. These difficulties led to loss of staff motivation and a distraction away from premium collection to loan recovery.

2.4

Insurance for MFIs?

Besides considering what insurance products to offer their clients, microfinance institutions also need to consider their own insurance needs. Interestingly, AIG's involvement in microinsurance in Uganda began during negotiations on commercial coverage for FINCA. MFIs working in partnership with an insurance company should consider packaging their entire insurance needs – those of the MFI and its clients – into the discussions to achieve a better deal. In addition, if staff are covered by some of the policies that they also sell to the MFI's clients, it helps ensure that staff understand the policy. If they do not like the product, there is a strong likelihood that the MFI's clients will not like it either.

In general, MFIs should assess whether they need the following types of corporate coverage:

- **Life and health insurance for employees:** MFIs should be concerned with protecting their most valuable assets, their employees. Modest investments in life and health cover for employees and their families can reap significant returns in the form of staff retention, high productivity and fewer working days lost to illness.
- **Fidelity insurance:** Bonds guarantee a payment or a reimbursement of financial losses resulting from dishonesty, failure to perform and other acts. One type of bond is fidelity insurance, which protects the MFI from losses incurred due to fraudulent acts perpetrated by specified types of staff.
- **Money storage and handling:** Any MFI that stores or transports cash is vulnerable to theft. As the amount of cash in the safes or being transported to banks increases, MFIs would be wise to supplement their internal control and security policies with insurance coverage.
- **Property loss or damage:** Many microfinance institutions have a lot of money invested in their branch and head office infrastructure, and those offices are often located in high-risk communities. Certainly, protection against fire, vandalism and other property loss is worth considering.
- **Deposit insurance:** In many countries, deposit insurance is a public service provided by or in association with the central bank for regulated deposit taking institutions. However, such an arrangement could be delegated to an insurance company that has better information about the health of certain financial institutions than the central bank. For example in Poland, TUW SKOK provides deposit insurance on all savings accounts in credit unions up to €20,000 (US\$25,000).

3

Conclusions

There are no reasons why an MFI has to offer insurance. Indeed, most MFIs should focus on improving the effectiveness of their lending activities and introducing savings facilities before they distract themselves with insurance.

If an MFI decides to offer insurance, it needs to recognize that it cannot address all risks for everyone; it needs to determine the most cost-effective way to help clients solve their primary problems without undermining the organization's core business. It also should consider if it has sufficient skills to provide insurance, either on its own or with an insurance company. Insurance training for microfinance managers will strengthen their ability to negotiate appropriate products on behalf of their clients.

Microfinance institutions that are keen to offer insurance to protect themselves, their clients, or both, should explore the potential for partnerships with insurance companies. Where such partnerships are possible, they should adapt the products and systems to accommodate the characteristics and preferences of the low-income market. Where the regulatory environment allows, MFIs or associations of MFIs could also consider creating brokerage firms or even their own insurance companies, although these need to be managed at arm's length to ensure that credit policies do not influence insurance policies, and vice versa.

When determining what products to offer, and through what channels, an important consideration is how an MFI can best create an insurance culture in its target market. For example, what can the MFI do in terms of product design, service standards and customer education to create conditions in which low-income households appreciate insurance and are willing to pay for additional benefits?

There remains a gap between the risks that the poor really worry about – such as affordable healthcare and protection from natural disasters – and the insurance products that MFIs can realistically offer, even in partnership with an insurer. Microfinance institutions have to be realistic about what they can and cannot provide, and at what cost. Indeed some types of insurance for the poor, such as health insurance, may need to be subsidized, which might not make sense for an MFI with a commercial business model.