

MICROINSURANCE

Improving risk management for the poor

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The CGAP Working Group on Microinsurance, comprising of representatives from donors, multilateral agencies, NGOs, private insurance companies and other interested parties, was established in 2001 to promote the development of insurance services for the poor through increased stakeholder coordination and information sharing. Currently chaired by the International Labour Organization (ILO), the Working Group is organised into four subgroups: Operations and Donor Guidelines, Demand, Regulation and Dissemination. To share information about microinsurance initiatives, the Working Group issues this quarterly Newsletter. For more information contact Craig Churchill, churchill@ilo.org.

► Operations and Donor Guidelines subgroup: Tries to facilitate the emergence of appropriate insurance products for low-income persons, analysing current practices and improving donor practices in this field. Contact: mjmccord@bellsouth.net

► Demand subgroup: Seeks to develop tools that MFIs and other organisations can use to assess the demand for insurance and other risk-managing financial services. Contact: moniquec@microfinanceopportunities.org

► Regulation subgroup: Will focus on regulatory issues that affect the development of microinsurance products for the poor. Contact: Svenja.Jungbluth@gtz.de

► Dissemination subgroup: Facilitate microinsurance information sharing among the industry, including MFIs, insurance companies, donors and experts. Contact: insurance@microfinance.lu

To receive the coming issues of MICROINSURANCE, please contact insurance@microfinance.lu

Concept

Risk and Risk Management

The Impact of Shocks

In assessing the potential demand for microinsurance, a key question is: What coverage can be provided at what cost? This paper starts out by turning the question on its head and asks: What is the impact of a shock on poor households in the absence of insurance? How vulnerable are the poor?

Vulnerability is defined in terms of the ability of individuals and households to deal with risk. For the poor in Tanzania, Uganda, and Kenya, the research shows that the impact of a shock is a two-stage process (see Figure 1):

1. The immediate impact of the loss of an asset and/or income, and the need for lump sums of cash.
2. The medium and longer-term repercussions that call for strategic choices by households as they reallocate resources to respond to curtailed cash flows and the loss of assets and work to get back on their feet.

Responses to both levels of shock involve different strategies, which vary according to a household's resource endowment and the range of coping mechanisms it can access. The least stressful responses usually involve modifying consumption, calling in small debts, improving household budgeting, or using formal or informal

insurance mechanisms when available. Somewhat more stressful strategies involve drawing down savings, diversifying income sources, borrowing either formally or informally, and seeking help from friends and relatives. As a last resort, people may deplete assets, default on loans, take children out of school, or use other strategies that hinder their future productive capacity.

The Risks

Sickness, death of an income earner or other family member, and property loss as a result of theft or fire were, respectively, the most frequent and stressful risks among the study participants in all three countries.

Risk Management

Among East Africans the dominant mode for responding to these shocks remains self-insurance. The person or family retains the risk of loss themselves by borrowing from MFIs, ROSCAs, or moneylenders, or depleting assets such as savings and consumer durables. Figure 1, below, notes the primary and secondary impacts related to risk events and how individuals and families respond to these shocks.

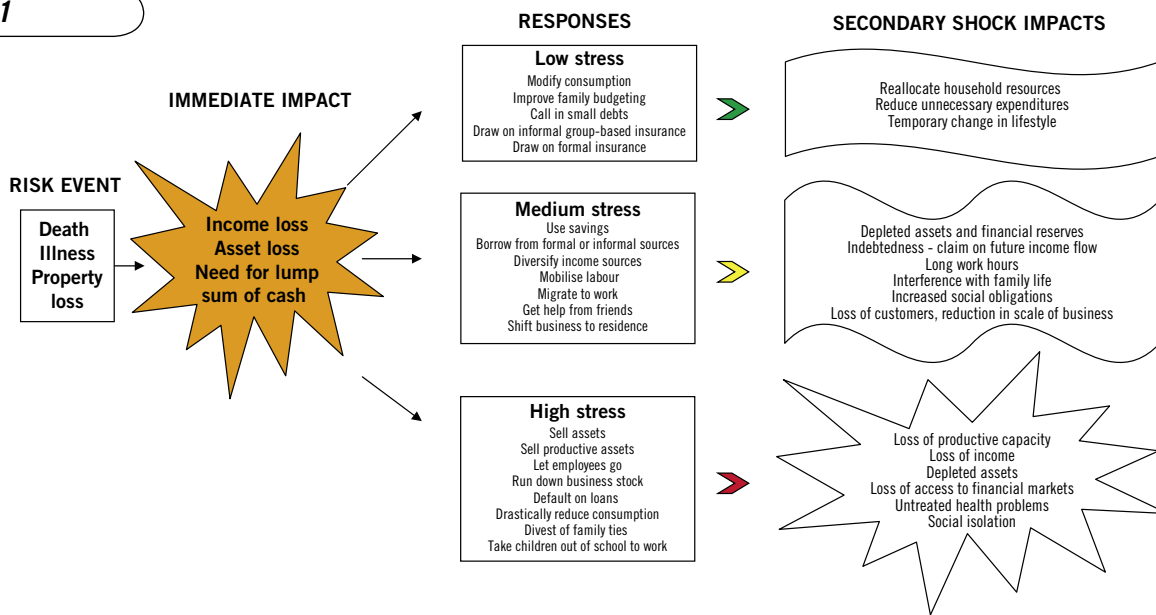
Risk and Risk Management.....	1
Indian Microinsurance:	
Breeding Ground for Innovation.....	3
Terms and definitions	5
Latest publications.....	5
About an insurance company.....	6
News from the Working Group	6
Events.....	6

Beyond self-insurance, a majority of study participants also use a wide array of informal group mechanisms both to manage risk ahead of time (*ex ante*), and cope with shocks after they occur (*ex post*). Burial societies and Friends in Need groups¹ are widespread in all three countries. These membership groups require payment of dues in return for the right to access group resources, in cash or in kind, for a specified need (for example, funeral transport or burial expenses). For frequent risks that require repeated expenditures of small sums of money, such as sickness, people often draw upon other informal groups such as the extended family and friends. Kenyans sometimes use fundraisers or "*harambees*" to mobilise the large sums of money required for hospitalisation or surgery (as well as other expensive activities like weddings).

Poor households interviewed in the demand study had very few formal insurance options to respond to risks. Exceptions include:

1 Known as *Munno Mukabi* in Uganda.

FIGURE 1



- Life insurance linked to their credit products is required by several MFIs in Uganda. In the event of the borrower's death, the outstanding balance is paid and the client's family receives a lump sum that varies in amount with the size of the loan balance and/or the cause of death. Often these policies also cover the spouse and a fixed number of children. One such product, offered by AIG Uganda, covers the lives of over twelve percent of the entire Uganda population.
- Health microinsurance such as the products offered by the microinsurers studied for this paper.

Coping Differences by Gender

While the occurrence of shocks is widespread, their impact can be uneven. With fewer assets, less control over assets, and lacking ways to exercise their legal rights to assets, women often find themselves more vulnerable than men. Among the informal group-based insurance options, some welfare societies exclude women-headed households. Self-insurance, a key strategy, is a weaker option for women who are resource-poor and thus are more limited in their ability to use savings, divert income, or borrow. To cope with loss, women exhibit some complex yet inventive risk management behaviours to protect themselves against future risks or to have timely access to lump sums of cash when an emergency occurs. For example, as a precautionary strategy, some women belong to more than one informal insurance scheme or become clients of multiple MFIs to widen their options.

Traditional Practice: Leaving Widows With Nothing

Lea is a client of the Youth Self Employment Foundation in Tanzania. After bandits killed her husband in 1993, she observed "edda" (i.e. stayed in isolation for three months) in accordance with Muslim tradition. While she was observing the "edda", her brother-in-law sold all the household's property including a car and a house that was under construction. He also took all of the household's savings. Though Lea had used the income from her own microenterprise to help build the household's assets before her husband's death, she and her children were left with nothing. Her business did not generate enough income to feed her four children, pay the rent, health bills, or school fees, and she struggled to make ends meet. (Millinga, 2002)

Coping Differences by Wealth Levels

While everyone stands to benefit from formal insurance, few among the poor currently see it as an option. In all three countries, formal insurance is viewed as the province of the rich and affordable by only the top economic levels of the population. There is a sense that only higher-level wealth groups can afford to take more precautionary measures to avert illness and to protect against property loss due to theft and fire. At the same time, informal insurance already is part of the daily lives of the urban and rural, rich and poor, even if

they do not define these mechanisms as "insurance." Many actively participate in welfare associations such as burial societies, which are informal precautionary mechanisms. However, poorer households primarily depend on risk management strategies involving reacting to a shock *ex post*. Coping with shocks can bring costs that are way beyond the cash flow capacity of most households and can drain them of existing resources. Feeding the family and keeping children in school when cash flow is reduced or interrupted are among the heavy burdens that must be addressed. Coping strategies that involve borrowing often exacerbate the pressures of debt that overhang many poor households and make the escape from poverty seem ever more distant.

The very poor have fewer options for managing risk proactively and often fall out of informal group-based systems, if they cannot keep up with the reciprocal obligations. With often weak state systems of social protection, they must then depend almost entirely on self-insurance mechanisms that are likely to be grossly inadequate. A few are lucky but many remain in debt, moving from crisis to crisis in a permanent race to stay one step ahead of the next shock.

Source: *Reducing Vulnerability: Demand for and Supply of Microinsurance in East Africa*, December 2003, Monique Cohen, Michael J. McCord, and Jennifer Sebstad.

Case Study

Indian Microinsurance: Breeding Ground for Innovation

Microfinance in India is often criticised for lack of innovation and for its heavy emphasis on replicating one delivery model: the self-help group (SHG).² Yet microinsurance is quite another story. Of all countries, perhaps the most significant microinsurance experiments are taking place in India.

There are several reasons for this. First, since the liberalisation of the insurance industry in the late 1990s, India has witnessed an insurance boom. Second, at the grassroots level, India is flushed with organisations that engage in financial transactions with the poor, particularly through SHGs which reach more than 10 million persons. The third and most important reason brings insurers and the civil society organisations together. The Indian Regulatory and Development Authority (IRDA) requires insurance companies to conduct portion of their business in rural areas covering the social sector. Furthermore, the Indian Government has realized the need for social protection for the informal economy and subsidises some schemes implemented by public insurance companies. While subsidies and priority sector requirements may not go over well with the free market crowd, they have certainly contributed to India's burgeoning microinsurance activities.

This article looks at three up-and-coming microfinance institutions (MFIs): Self-Help Promotion for Health and Rural Development (SHEPHERD) and Activists for Social Alternatives (ASA) in Tamil Nadu, and SPANDANA in Andhra Pradesh.³ Together they demonstrate the diversity and creativity found in Indian microinsurance.

Product Overview

Diversity is first apparent in their attitude toward insurance. SPANDANA, which acts as its own insurer, approaches it like a business; insurance is good because it contributes to the bottom line. ASA also has a professional approach to microinsurance, but it balances client and institutional needs. SHEPHERD maintains a strong development attitude and adopts a holistic perspective to helping

low-income persons to manage risks, but it is not yet clear whether this approach is sustainable.

Diversity is also evident in an overview of the main products offered by the three MFIs (see Table 1). Although each MFI offers life insurance, they are three very different products.

SPANDANA offers a compulsory credit life product, which benefits the MFI by generating an additional revenue stream and lowering credit risk. The additional coverage for the member's spouse (Rs. 5,000) is an important selling feature—to date, there have been three times as many claims for spouse death than member death. The credit life product also includes hut coverage, providing a benefit of Rs. 1000 if a member's house burns or is damaged.⁴

ASA's term life insurance offers a flat sum assured (Rs. 20,000) regardless of the cause of death to simplify claims procedures. Although it is voluntary, borrowers are strongly encouraged to purchase the coverage. SHEPHERD actually offers three different Life Insurance Corporation (LIC) products, although the GSS described in Table 1 is the cheapest and most popular. Recently the organisation has expanded its outreach by offering life insurance to non-members who are unrelated to the SHGs, which has the potential to expose the insurer to a significant adverse selection risk.

SHEPHERD began offering health insurance in 2003, although it is really a hospitalisation product with a lot of other add-ons. This bucket cover, designed with the United Indian Insurance Company (UIIC), includes hospitalisation expenses, accidental death (including transport costs of the body), hut insurance, permanent disability, and a short-term allowance for disability and hospitalisation. Uni Micro, as the product is called, is an experiment for both SHEPHERD and UIIC. In fact, because the modifications substantially changed the product, the insurer had to obtain approval from the regulatory authority to launch it.

Regarding asset coverage, SHEPHERD and SPANDANA offer hut insurance, al-

though primarily through other products (Uni Micro and credit life respectively). ASA and SHEPHERD offer livestock insurance. Although not mentioned in Table 1, ASA's livestock cover was its first foray into microinsurance in 1991. Over the years, the scheme has gone through a number of product design changes and partners. Its current product, offered in partnership with New India Assurance, is compulsory for all cattle loans. SHEPHERD offers the same livestock product, on behalf of UIIC, although it charges 4 percent of the animal's value (compared to 5 percent at ASA) and it is voluntary. Less than half of SHEPHERD's cattle loans are insured.

Delivery Model

One of the most interesting lessons from these MFIs comes from their efforts to negotiate with insurance companies. All three have used the partner-agent model and have experienced significant claim settlement delays. SPANDANA adopted a hard-line stance. When it could not get sufficient claims service, SPANDANA terminated its contract with the insurance company and has been offering insurance in-house ever since.

ASA has switched several times between different insurance companies and self insurance in an effort to find an appropriate solution. During one of its self-insurance periods, several members were involved in a truck accident, which helped ASA realise that it was vulnerable to covariant risks. Experience with six different insurance partners between 1998 and 2003 provided ASA with a keen understanding of its product design and service requirements. As ASA grew to 60,000 members, it became a more attractive partner for insurance companies. In 2003, ASA invited a dozen insurers to negotiate a partnership, and selected two: Allianz-Bajaj and AMP Sanmar, which are now covering different regions and competing to see who provides better service.

SHEPHERD also earned valuable concessions. When negotiating with UIIC, SHEPHERD insisted on an Insurance

2 The self-help group model brings together 15 to 30 women into an informal savings and credit cooperative. After a number of months of managing their own savings and internal loans, they are able to access external loans from a bank - for this reason, the SHG approach is sometimes referred to as the bank-linkage model.

3 All three organisations are members of Friends of Women's World Banking (FWWB), a non-profit apex organization. Founded in 1982, FWWB provides support to microfinance institutions (MFIs) and networks within India, and links its members to the global movement. For the last six years, GTZ has supported FWWB's microinsurance activities, which includes capacity building and technical assistance to nine of its members.

4 The exchange rate is roughly Rs. 45 to US\$1, so Rs. 1000 is \$22, Rs. 5000 is \$111, and Rs. 20,000 is \$444.

TABLE 1

Table 1. Insurance Product Summary: ASA, SHEPHERD and SPANDANA

	ASA's Life Insurance	SHEPHERD Life Insurance	SHEPHERD Accidental Death and Hospitalisation	SHEPHERD Cattle Insurance	SPANDANA Credit Life Plus
Group or individual product	Group	Group Social Security Scheme (GSS)	Group—Uni Micro Health Insurance Scheme	Group	Group
Term	1 year	1 year	1 year	1 year	Loan term
Eligibility requirements	SHG member or spouse, age 18-60	Age 18-59	Age 18 to 60 Declaration of good health	Veterinarian certificate of health, immunization and valuation	SPANDANA borrower
Delivery model	Partner-agent, comparing the performance of two insurers	Partner-agent with LIC	Partner-agent with UIIC	Partner-agent with UIIC	Full-service
Voluntary or compulsory	Mostly compulsory	Compulsory at group level for SHGs Voluntary for non-members	Voluntary	Voluntary	Compulsory
Product coverage (benefits)	Rs. 20,000 for any death (natural or accidental)	Rs. 5,000 natural death Rs. 50,000 accidental death Rs. 12,500 permanent disability	Rs. 15,000 accidental death Rs. 15,000 permanent disability Rs. 250/month up to max Rs. 750 for temporary disability Rs. 5,000 hospitalisation expenses Rs. 5,000 for house fire and allied perils	Value of animal (usually around Rs. 10,000) upon natural or accidental death	Loan amount if the borrower dies Rs. 5,000 if spouse dies Rs. 1000 for hut damage
Key exclusions	No exclusion for suicide, no waiting period	None	30 days waiting period (except for accidents); exclusions for the hospitalisation cover include childbirth pre-existing conditions, and HIV/AIDS	Intentional death caused by owner	None
Pricing	Member pays Rs. 125; Rs. 36 goes to insurance partner	Member pays Rs. 35; Rs. 25 goes to insurance partner	Member pays Rs. 100; Rs. 84 goes to the insurance partner (an additional Rs. 20 is charged for thatched roof houses)	Member pays 4 percent of the animal's value; 2.25 percent goes to the insurance partner	1 percent of loan amount or Rs. 50, whichever is higher
Number of policyholders	26,835 with Allianz Bajaj 26,885 with AMP Sanmar	6500	550	126 in 2000 350 in 2001 302 in 2002 85 in 2003	84,000 (including spouses)

Review Committee, consisting of representatives from the insurer, insured members and the MFI. This committee will meet every two months to ensure that the underwriting and claims processes are properly implemented. If there are any problems, the committee will suggest measures to make the service more effective.

Lessons

From the experiences of these three organisations over the years, a number of additional lessons can be identified:

- **Balancing benefits and simplicity.** Although the benefits of SHEPHERD's health product are customer oriented, the complexity is difficult to comprehend, for clients and staff alike. Thus clients may not fully utilize their rights and entitlements—especially when offered along with 3 life insurance options, livestock cover and various savings and emergency loan products.
- **Accidental death complications.** For several years, ASA offered life coverage that paid a higher sum assured for accidental death than natural death. This marketing manoeuvre may help sell policies, but when claims start coming in, the paperwork and hassles involved in delineating between natural and accidental deaths caused significant confusion and poor service. To simplify its most recent product, ASA told its partners that it wanted one price for all deaths, regardless of the cause.
- **Pricing.** Another simplification promoted by both ASA and SHEPHERD when negotiating with insurance partners was the pricing of products based on the average age of the clients. For example, UIIC wanted two age categories for Uni Micro—18 to 45 and 46 to 60—but SHEPHERD's focus group discussions indicated that this would cause problems in some SHGs if some members were paying more than others.
- **Voluntary.** SHEPHERD insists that an experimental insurance product, like Uni Micro, should be voluntary, at least at first. Voluntary products give organisations a better understanding of the true demand and stimulate useful feedback from the group members that would not come if the product was mandatory. Plus staff develop a better understanding for products that they are expected to sell.
- **Claims management I.** In the field, the most common problems with death claims are: 1) obtaining a death certificate and other required documents, which can be time consuming and costly; and 2) payment of the claim by cheque, because most beneficiaries do not have bank accounts. SHEPHERD solved the second problem by negotiating with LIC to issue a cheque to the MFI, which then pays the beneficiaries in cash. ASA is trying to take it one step further by negotiating with its partners for a claims float, paid to ASA in advance, allowing the MFI to immediately pay claims and then reconcile with the insurer at the end of each month. Both ASA and SHEPHERD are also trying to solve the first problem by convincing insurers to accept unofficial documentation, such as a letter signed by all SHG members. Because SPANDANA manages its own product, it does not have these problems.
- **Claims management II.** SHEPHERD recognises that Uni Micro will have its own claims challenges since clients are expected to pay for hospitalisation expenses and then be reimbursed by the insurer. The organisation is currently considering a way to facilitate this process, perhaps through a short-term loan.
- **Risk management approach.** Microinsurance is only one risk management strategy. SHEPHERD clearly recognises this as it offers saving and credit products that can

be used for risk management, as well as non-financial services intended to prevent risks, such as health care camps and veterinarian services.

- **Sustainability.** For all three organisations, it is very difficult to determine the profitability of their insurance products because they do not measure the costs associated with insurance delivery.
- **Client satisfaction.** The concept of insurance (risk pooling) is still difficult to convey. Many clients expressed a preference for getting some money back if they do not submit a claim. SHEPHERD is perhaps the most diligent about regularly assessing

client satisfaction and soliciting feedback for product improvements.

- **Marketing.** All three organisations use claims payments as a marketing opportunity by handing over the benefits in public ceremonies.
- **Partner negotiation.** In its comprehensive approach to selecting new insurance partners, ASA used its experience and scale to leverage improvements to its products and prices. To accommodate ASA, AMP Sanmar removed the suicide exclusion (usually applicable in the first year), waived medical and work certificates, raised the age limit and came down in price.

The experience of these three organisations indicates that the partner-agent model is far from perfect, but through negotiations there is scope for improvements. This brief overview is just a taste of things to come. Close attention to the experiences in India, a hotbed for micro-insurance innovation, is bound to produce a deluge of additional lessons, especially about the relationship between grassroots delivery agents and the formal insurance industry.

Source: Craig Churchill and Gaby Ramm⁵, 2004

⁵ The authors thank Namerta (GTZ) and Jim Roth (ILO) for their assistance with this article, as well as the staff and management of SPANDANA, ASA and SHEPERD.

Terms and definitions

Cover or coverage: The scope of protection provided under an insurance contract.

Covariant risk: A peril that affects a large number of the policyholders at the same, e.g., an earthquake; or several risks that consistently occur together (at the same time or under the same circumstances).

Deductible: Also known as excess, an amount that a policyholder agrees to pay, per claim or per accident, toward the total amount of an insured loss. Insurers use this mechanism to share risk with policyholders and reduce moral hazard.

Insured event: The trigger event that leads to the submission of a claim (e.g.: death of the policyholder).

Source: *Making Insurance Work for Microfinance Institutions*, ILO, 2003.

Selected Info

Latest publications

The **Microinsurance Center** recently published five new **Briefing Notes**, which cover a particular aspect of microinsurance:

BN2: How Poor People Manage Risk?

BN3: Making Microinsurance Work for Clients?

BN4: An Example of Systematic New Product Development for Life Microinsurance

BN5: Lessons from Health Care Financing Programs in East Africa

BN6: Financial Risk Management Tools for the Poor

All these documents are available at <http://www.microinsurancecentre.org/index.cfm?fuseaction=resources.documents>

Microinsurance within the Insurance Market Interafrican Conference (CIMA), a Field to Regulate? L. Lhériaux in *Techniques financières & développement* n° 73 – ESF – 2003. Info: www.esf.asso.fr

Microinsurance: a Risk Management Strategy. Donor Brief n°16, CGAP, December 2003, A. Latortue with inputs from M. Cohen, M. J. McCord, C. Churchill and CGAP Staff. Available at http://www.cgap.org/docs/DonorBrief_16.pdf

Guide de gestion des mutuelles de santé en Afrique (A Management Guide for Promoters and Managers. Mutual Health Insurance Organizations in Africa). BIT/STEP, 2003.

Info: <http://www.ilo.org/public/english/protection/socsec/step/reslib/publ.php?idpubl=10>

The document **Making Insurance Work for Microfinance Institutions. A Technical Guide to Developing and Delivering Microinsurance** is now available in French. C. Churchill, D. Liber, M.J. Mc Cord, J. Roth – ILO, 2003.

Info: http://www.microfinance.lu/ada/internal.php?c_n=201

Selected Info (continued)

About an insurance company

CIC, Kenya, sees growth in microfinance sector.

The Co-operative Insurance Company (CIC) was established in 1978 as a specialist insurer to cater for the insurance needs of the co-operative movement in Kenya. The co-operatives felt that their needs were not being appropriately met by the private commercial insurance companies, which, out of misunderstanding the co-operative decision making process, perceived co-operatives as being mediocre and inefficient. CIC is wholly owned by the co-operative movement and it offers a wide range of non-life and life insurance products catering for varied needs of co-operatives, commercial organizations and the general public. Currently CIC has established relationships with a number of Microfinance institutions, i.e. Faulu Kenya, Kadet (World Vision), Small Microfinance Enterprise Programme (SMEP), ICDC, IDB, Co-operative Bank of Kenya Limited, Wedco and various microfinance programmes with Saccos. To all these institutions, CIC offers a specialized insurance product designed uniquely to cover risks such as death and permanent total disability of the loanees, fire and burglary on indemnity basis. This product is quite flexible and can be extended to cover funeral expenses and group personal accident of the loanees. The flexibility and customizing of this product enables the members of the microfinance sector to access affordable insurance cover and takes account of their different needs. CIC is currently exploring how its individual life products can be distributed to the members of microfinance institutions with which relationships already exist. Source: <http://allafrica.com/stories/printable/200402170078.html>

Events

Hivos, The Netherlands, organized an expert meeting on microfinance and HIV/AIDS on April 15th, 2004. Microinsurance is considered to be a potential interesting new product in this field since it might contribute to better manage risks for the clients as well as for the microfinance institutions. Info: c.gommans@hivos.nl

News from the Working Group

Operations and Donor Guidelines sub-group

Since November 2003, the Working Group has disseminated the Preliminary Donor Guidelines for Microinsurance. The objective at this stage is for project managers to put the Guidelines to practice to see: (i) which parts of the guidelines are practical and which parts are irrelevant; (ii) what works and what does not; and (iii) is there anything that they disagree with and is anything missing. This information should be channelled back to the Working Group over the next year so that appropriate adjustments can be made to the Guidelines. Only then, the document would be formally endorsed as Donor Consensus Guidelines. The document is available at http://www.microfinancegateway.org/files/13836_Draft_Donor_Guidelines.pdf and comments might be sent to Craig Churchill at churchill@ilo.org

Demand sub-group

The Demand sub-group recently shared its agenda for the coming year. Experience shows that microinsurance products and services differ from traditional insurance in terms of design, coverage, pricing, and the way premiums are calculated. To ensure that the services are appropriate, it is necessary to undertake market research to assess demand and to identify the role of microinsurance in relation to informal insurance mechanisms, self insurance as well as the role of the state in providing social protection. To date there have been only a few such studies and this is why, the Demand sub-group will undertake some demand studies to not only build up the store of knowledge on customer needs but also to provide a basis for developing guidelines for undertaking demand studies on microinsurance. Info: Monique Cohen at moniquec@microfinanceopportunities.org